JEFFERSON COUNTY HUMAN SERVICES DEPARTMENT

2009
ANNUAL REPORT

Serving the Residents of Jefferson County

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JEFFERSON COUNTY HUMAN SERVICES DEPARTMENT
Serving the Residents of Jefferson County
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May, 2010

Dear Mr. Molinaro, County Board Chair,
Members of the Jefferson County Board,
Members of the Jefferson County Human Services Board,
Mr. Petre, County Administrator,
Jefferson County citizens,
And other interested parties,

I am pleased to present the 2010 Jefferson County Human Services Department annual report. On behalf of the department, I would like to thank you all for the support you provided over the last year.

In 2009 we organized into six divisions. I would like to briefly review the major trend in each division for that time period.

- The Economic Support Division provides resources for low income households and those experiencing financial loss. The number of households accessing these services rose over 30%.
- The Behavioral Health Division provides a full array of mental health and alcohol and drug services to a variety of consumers. The number of Emergency Mental Health calls in this area increased over 270%.
- The Family Resource Division, which delivers a number of programs to children and their families, saw an increase in child abuse and families in need of support and services.
- The Aging and Disability Resource Division provides services for people who are elderly or disabled. This division saw a substantial increase in elder abuse, the need for benefit specialists' services, information and assistance, and in requests for publicly funded long-term care.
- Our Administrative Services Division completes all the maintenance, support, and fiscal duties required to operate the department. This division worked in partnership with the entire department to implement cost savings measures and to review all systems for fiscal accountability.
- Our Developmental Disabilities/Long Term Care Division completed the transition to Family Care. As of January 1, 2010 the Department no longer provides these services or operates this division. People who are elderly, physically disabled, or developmentally disabled are now served by our care management organization, Care Wisconsin, through the state contract for Family Care. Staff are to be commended for their work throughout this transition.

Given the economic times, there has been an even greater need for the services of the department. Over 20% of our county households have needed public resources in the last year. We are determined to provide them with the best.

Please review our entire annual report. We believe in being responsive to community needs and to each of our stakeholders. We are committed to delivering outstanding programs that are cost efficient for our community. We need your input to do that. Please contact us at anytime at 674-3105. We look forward to hearing from you.

Thank you,

Kathi Cauley
Director
Jefferson County Human Services

MISSION STATEMENT

Enhance the quality of life for individuals and families living in Jefferson County,
by addressing their needs in a respectful manner,
and enable citizens receiving services to function as independently as possible
while acknowledging their cultural differences.

VISION STATEMENT

All citizens have the opportunity to access effective and comprehensive
human services in an integrated and efficient manner.

HUMAN SERVICES BOARD OF DIRECTORS

2009 – 2010

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John McKenzie

Martin Powers

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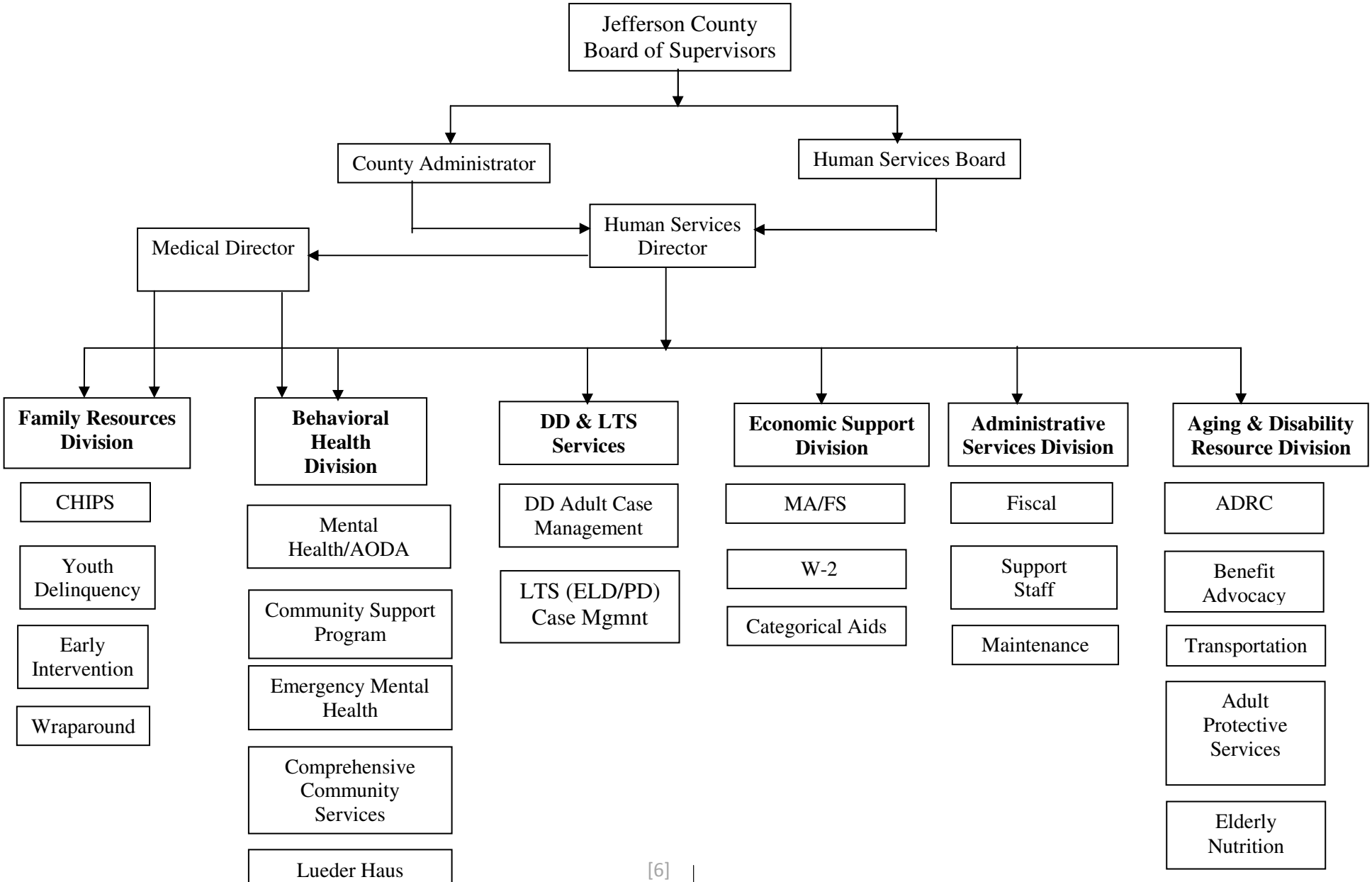
2009 Organizational Chart



ECONOMIC SUPPORT DIVISION

~ Providing and Coordinating Resources to Strengthen Families~

ACCESS to Resources and Quality Customer Service are the main focuses of the Economic Support Unit. Our goal is to provide accurate, timely, and effective financial and case management support services for our customers.

The Economic Support Programs of Jefferson County are administrated at the Workforce Development Center. This location provides staff with the ability to coordinate the services of the on-site providers: Job Service, Department of Vocational Rehabilitation, Opportunities,Inc.,WIA (WorkSmart) Programs, Jefferson County Economic Development Consortium and UW-Extension. Community Partners also serve an important role in service coordination. Some of these partners include Community Action Coalition, Madison College, Local School Districts, various faith based organizations and Local Employers. Employment services are provided regionally to facilitate coordination of customers who live in one county and are employed in another.

If you are interested in learning more about the agencies and services available to meet your workforce needs, you can visit the Workforce Development Center's website at http://www.comeherefirst.org or www.JobCenterOf Wisconsin.com.

Presently, our Economic Support Programs are serving over 5,237 .Jefferson County households per month. This is an increase of over 30% since 2007. Customers may be receiving assistance from Medicaid, BadgerCare Plus, FoodShare, Wisconsin Shares, Wisconsin Works, and/or Kinship. Further, our customers may also receive financial assistance from St. Vincent de Paul or Energy Assistance.

Following is a brief description of each program and the number of customers who received these benefits in 2009.

Wisconsin Works (W-2)

Jefferson County has successfully been awarded the grant funding for the W-2 program since its inception in 1997. The W-2 program focuses upon alleviating the specific employment barriers a participant may have by providing intensive case management and service coordination. The W-2 program determines how a customer's strengths can be enhanced in order to enable them to obtain employment and achieve self-sufficiency.

Many W-2 customers may have complex circumstances which will be reviewed by the Financial Employment Planner (FEP) with the goal of developing an individual employability plan that isolates the household's employment barriers. These barriers could be transportation, education, training, physical or mental disabilities, or the care of a child under the age of 12 weeks. The FEP will use a variety of tools, including work experience, employment workshops, career development, one to one counseling and in addition they will coordinate services for housing, literacy and energy assistance. Through strong case management, the goal is for the customer to successfully return to the workforce with the supportive programs of Badgercare Plus and FoodShare providing the continued stabilization needed.

Customers enrolled in the W-2 Program are required to participate in developed activities for 40 hours per week. After completing their participation, the customer will receive a monthly payment of $628.00 or $673.00 per month depending upon their employment placement.

The number of yearly participants in the W-2 program remains low since the participation requirements are intense and the customer's needs may be able to be met through other financial assistance programs in lieu of W-2. The website for the Department of Children and Families is http://www.dcf.wisconsin.gov.

Unduplicated W-2 Participants

	2007	2008	2009
Participants	47	54	56

Economic Support Programs

The Economic Support Programs serve to provide greater financial stability for low income households and those experiencing a financial loss. Each program serves a specific population and has different income guidelines and requirements. The self-sufficiency of Jefferson County households and individuals is the ultimate program goal. The number of customers requesting financial assistance from Economic Support Programs continues to grow each year. Requests for the programs continue to increase due to the current economic conditions and the loss of health insurance. We continue to actively participate in the local Rapid Response sessions.

Caseload Growth

2006 4,068 households receiving assistance
2007 4,201 households receiving assistance
2008 4,710 households receiving assistance
2009 5,237 households receiving assistance

Requests for program assistance are made by contacting the Workforce Development Center at 920-674-7500 and asking to speak to an intake worker or coming into the agency. The FEPs serve as the first point of contact for all customers and they are responsible for assessing the customer's needs, initiating the application process and coordinating the appropriate referrals to community resources. You may also complete an on line application at www. access.wisconsin.gov, and the application will be directed to our office.

The Economic Support Programs continue to be modified and enhanced to meet our customer's changing needs. The ACCESS website (www.access.wisconsin.gov) allows the customers to complete a quick test for potential eligibility, apply for benefits on-line, report changes, complete renewals and check their benefits. This initial screening determines potential eligibility for numerous Economic Support programs including Foodshare, BadgerCare Plus, Medicaid, WIC, Energy Assistance and Earned Income Tax Credits. The customer is able to submit their application electronically to the agency and then provide the verifications needed at a later date.

MEDICAL ASSISTANCE is a State and Federally funded program that provides the low income customer with comprehensive, affordable healthcare. Numerous individual programs are included under the umbrella of Medical Assistance, such as, Badgercare Plus, Badgercare Core Plan, Medicaid Purchase Plan, Family Planning Waiver, Medicare Beneficiary and Family Care. Each program has its own specific financial and non financial criteria for eligibility. The eligible customer receives a white Forward card which they present to the Health

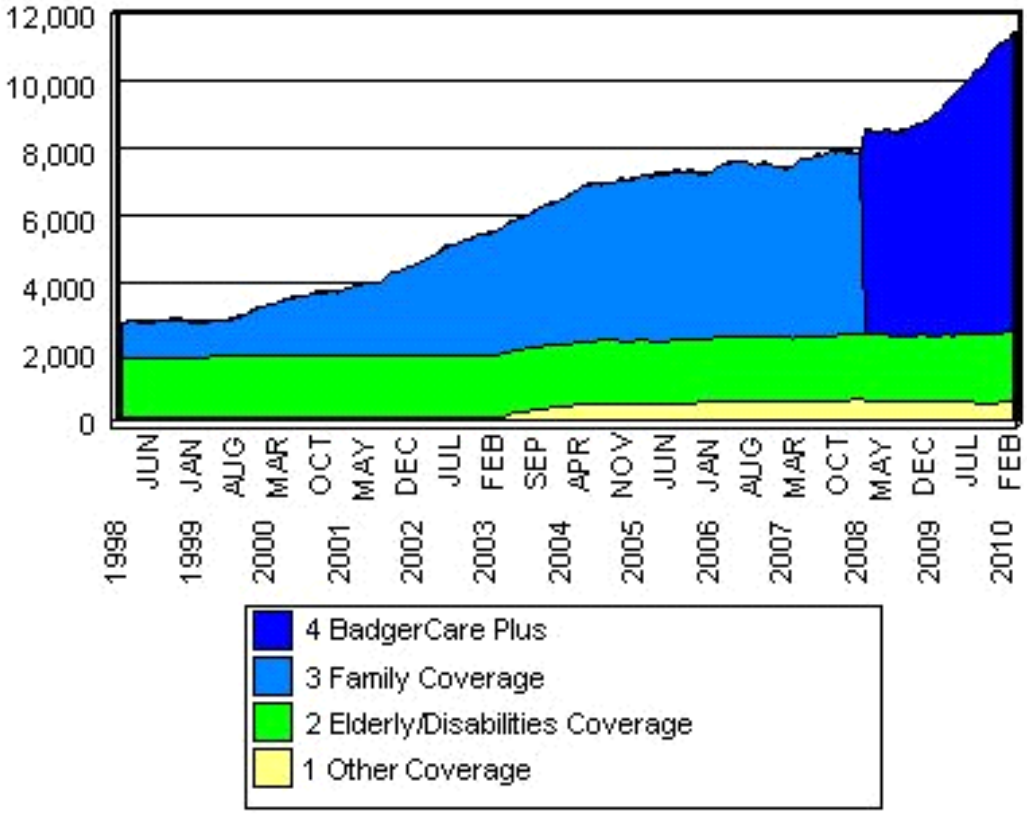
Care provider to verify coverage. Most Medical Assistance customers must participate in an HMO. The Medicaid website is http://dhs.wisconsin.gov from which you can access information on individual program benefits and requirements.

The following chart shows a continuous increase in the number of customers receiving Medical Assistance in Jefferson County. In 2008, we provided Medical Assistance coverage to 8,865 customers. In 2009, the number of customers eligible for benefits increased to 11,110. It is expected these participation numbers will continue to increase as health care expenses rise, and the economy slowly recovers.

NUMBER OF MEDICAL ASSISTANCE RECIPIENTS

Caseload on December 30	Families	Nursing Home	Disabled	Totals
2006	5,418	357	1,661	7,436
2007	5,802	321	1,745	7,880
2008	6,753	315	1,797	8,865
2009	8,354	271	1,906	11,110

JEFFERSON COUNTY RECIPIENTS SINCE 1998



FOODSHARE-Food Stamps is a Federal Program that provides a monthly Foodshare allotment to low income customers. Eligibility is based upon income, household composition and shelter expenses. The eligible customer receives a QUEST card that is used to purchase food at local grocery stores. Customers in search of employment may volunteer to participate in the Foodshare Employment and Training Pogram and work in coordination with a case manager to develop their employability resources. Like the Medical Assistance Programs, Foodshare participation continues to increase dramatically. The Foodshare caseload in December 2008 was 2,610 households with a total county wide benefit issuance of $373,600 per month. This is money that is spent at our local retailers. By contrast, in December 2009, the caseload was 3,457 households with a monthly benefit issuance of $563,912. Statistics show that 10% of the 5.6 million people in Wisconsin currently receive Foodshare benefits. The chart below shows the increase in the number of Foodshare customers from 2006 to 2009 in Jefferson County. The Foodshare website is http://dhs.wisconsin.gov/foodshare.

FOODSHARE

Year	All Recipients	Adults	Children	Groups
2006	5,118	2,519	2,623	2,055
2007	5,672	2,765	2,907	2,320
2008	6,376	3,209	2,907	2,610
2009	8,594	4,369	4,282	3,457

WISCONSIN SHARES-CHILD CARE is a program that provides child care subsidies for low income working families to assist in paying their child care expenses. The subsidy payment is made to the child care provider, with the family responsible for the co-payments. In 2008, the average monthly number of families receiving child care assistance was 252 households. In 2009, the average monthly number of families receiving assistance was 246 households. Additionally, the Child Care case managers certify in-home child care providers, participate in local children's fairs and present trainings for providers. The child care website is http://dcf.wisconsin.gov/childcare/wishares

KINSHIP is a program that provides monthly payments for non-legally responsible relatives caring for a child. The child may be unable to live with their parents due to incarceration, medical concerns or parenting issues. The relative receives a payment to help with the additional expenses. In 2008, 22 children per month received payments with 23 children on the waiting list. In 2009, 38 children received payments with 15 on the waitlist. The waitlist is necessary due to limited funding.

JEFFERSON ST. VINCENT DE PAUL SOCIETY provides our agency members with local funds that enable us to assist customers residing within the boundaries of the Jefferson School District with emergency needs such as rent and utilities. Customers may only receive a payment once in a 2 year time period. In 2008, St. Vincent de Paul provided $21,984.51 for 186 customers. In 2009, 142 customers received $16,181.44 in emergency funding.

EMERGENCY ASSISTANCE is a limited program designed to meet the immediate needs of an eligible family facing a current emergency of fire, flood, homelessness or impending homelessness. In 2008, 89 households received $41,230.42 with an average grant of $463.26 each. These households included 110 adults and 181 children. In 2009, 398 households received $185,922.13 with an average grant of $467.14. These households included 518 adults and 749 children.

HOUSING The housing coordinator's focus is to assist impending homeless and homeless families and individuals with locating and maintaining safe, affordable and accessible housing. In 2008, 151 families and 253 individuals received these services. In 2009, 151 families and 417 individuals were provided housing services. We continue to partner with Community Action Coalition and other local housing providers.

ENERGY ASSISTANCE is a program that provides a one time payment during the heating season to low income customers who need help paying their heating costs. The energy payment is made directly to the fuel supplier. Jefferson County continues to contract with Energy Services to administer the program. In 2008, 1,479 households received $510,137 in energy payments with additional crisis funding going to 213 households in the amount of $93,221. In 2009, 1,725 households received $728,237 in energy payments with crisis funding to 374 households in the amount of $165,151 Program information can be found at http://heat.doa.state.wi.us

Strategic Priorities for 2010

In 2010, the downturn and uncertainty of the economy continue to provide ongoing challenges for Economic Support. The high unemployment rate and the loss of health insurance have brought many new customers into the Workforce Development Center to access programs of financial assistance and re-employment services.
In order to meet these challenges, the Economic Support Division has established the following three strategic priorities:

******QUALITY CUSTOMER SERVICE -** This priority continues to be a challenge due to the increasing number of customers seeking assistance. In December 2009, staff processed 173 new applications, 359 reviews and 1,103 changes. We have eliminated much of the paperwork previously required by encouraging customers to apply on line or by telephone. All calls to the front desk are answered personally to assist in guiding the customer directly to the resource they want. Another strategy employed is to take the time to fully explain the program benefits and requirements to each customer. This reduces any potential frustration the customer may experience with the programs. Staff work together to meet our customer service goals, as do all center partners.

******TIMELY AND ACCURATE PROCESSING OF BENEFITS** - This priority is being met by continued training of the staff at weekly staff meetings and by participation at state sponsored trainings or workgroups. Our cases are continually monitored for accuracy through a State quality control process as well as a monthly internal process. Staff often share case responsibilities and through this collaboration also review each case for accuracy. Timely processing can be difficult due to the volume of applications but staff members have each developed their own organizational system and as a division we continue to initiate new, creative ways to manage the workload.

******FACILITATE ACCESS TO OTHER RESOURCES FOR EMPLOYMENT AND FINANCIAL SUPPORT** - This priority is met by the staff in the Economic Support Division through their comprehensive knowledge of all local, State and Federal resources beyond the programs that we directly administer. Staff is able to effectively refer customers to other WDC partners as well as community resources. Many staff are actively involved in community organizations in the areas of housing, health, food distribution and financial education. The networking developed is invaluable. We recently began presenting a monthly workshop which reviews all the resources available to meet a customers needs.

Cost savings enacted in 2009 include a reduction in the cost of postage by reduced mailings of paper applications, reviews and stamped addressed envelopes unless there is a need. We have also reduced the amount of information printed and increased the use of reading the information on line. Additionally, we continue to search for new grant funding either separately or in collaboration with other community partners.

Our challenges continue, yet these challenges can be met. The coordination of programs and community partners, new technology for easier program access, and the caring and knowledge of the Economic Support staff all provide the avenues necessary to meet these challenges.

FAMILY RESOURCES DIVISION

~ A Departmental value is keeping families together whenever possible and assisting them to live in their own communities. ~

The Children and Family Resources Division provides assistance to families in Jefferson County through a variety of programs and teams. These teams work across disciplines to create a seamless array of services that support families to move towards self-sufficiency and independence while maintaining safety for the children in the least restrictive settings. The teams that make up this division include; Intake and Assessment, Birth to Three, Pre-school, Alternate Care, Delinquency and Intensive Supervision , On-going Child in need of Protective services, Family Development, Wrap-around, Children's waiver and Family Support.

The Children and Family Resources Division staff have identified four priority areas to address in 2010. The first is permanence for children. Children have the right to live in a safe environment that is expected to last until they reach adulthood. This may include their birth family, relatives, foster care, guardianship or adoptive homes. The staff will keep permanence at the fore front of staff meetings and family teams along with working closely with the District Attorney and Corporation Counsel to assist with developing permanent plans for children. Delivering best practice is the second priority for the division. A quality assurance process is being developed to identify areas of strength and needs for all staff regarding the interaction that they have with families. Best practice supports an increase in permanence for children and families. The division believes that it will take the whole community to support children and families in Jefferson County which leads to the third priority community interaction. The primary goal for this area will focus on cross training within the agency and the community to increase communication, commitment to team work and education. Finally, the division has made fiscal responsibility a priority for 2010. In this time of global financial crisis it is essential for our division to be aware of the cost of services.

The staff of the Children and Family Division is dedicated to the community, their colleagues, the agency and most of all to the children of Jefferson County.

The Family Resource Team Includes:

- Children in Need of Protective Services
- Youth Delinquency, which includes the Delinquency Prevention Council, Restorative Justice, and the Agency Delinquency Team.
- Wraparound
- Early Intervention
- Children's Alternate Care
- Children's Waivers
- Independent Living

Children in Need of Protection and Services (CHIPS)

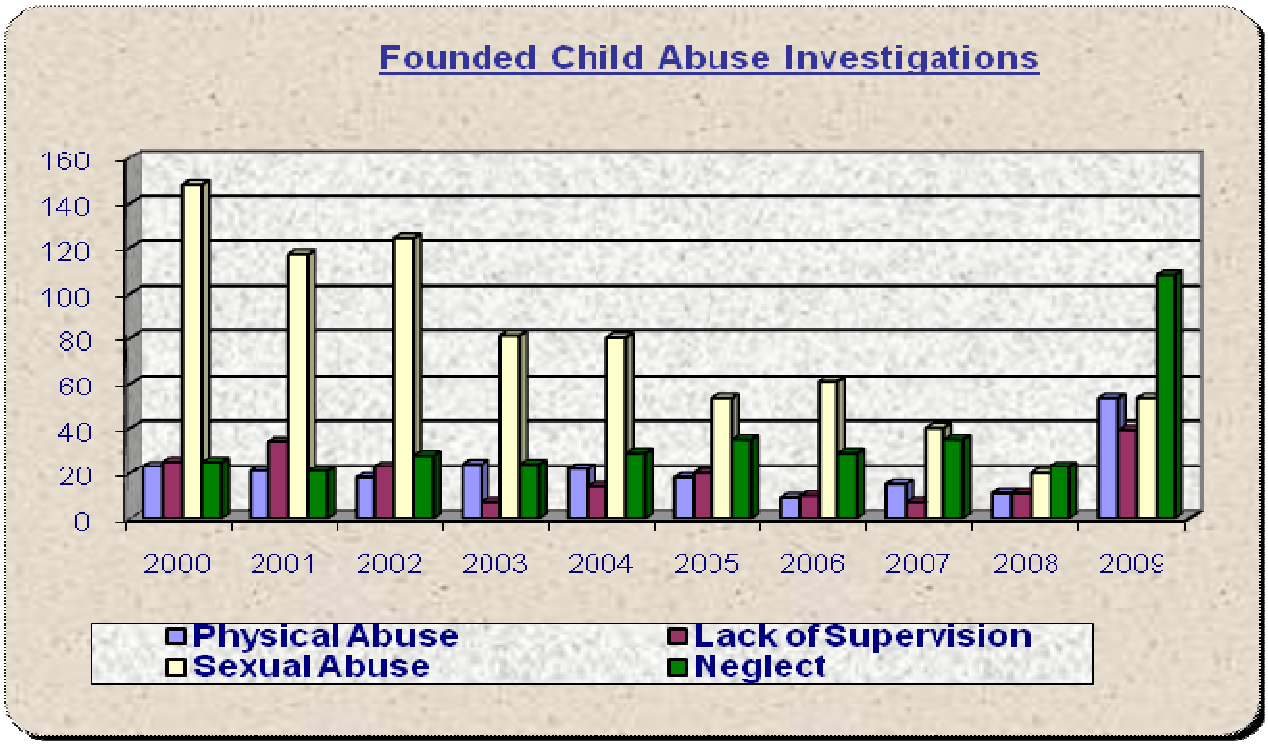
~ A program manager and team of social workers are specifically trained to assist families to improve their lives while protecting children~

CHILD ABUSE is a major concern and precursor to many other life problems therefore special attention is given to this area. Child abuse reports are received from members of the public including neighbors, relatives and friends of families where abuse or neglect is a concern or potential concern. A large number of reports are also received from schools, police departments, physicians and other service providers or professionals. Each report is handled according to our legal requirements for child abuse investigation and child protection. The procedures involved with child protection investigations have become more comprehensive and time consuming over the past several years. The number of reports and founded investigations continues to be on the rise in Jefferson County. In 2008 there were 354 reports of child abuse made to the agency. In 2009, this number increased to 614 for a 43% increase in calls that required a response from staff. These calls have been handled by the same number of staff who may spend anywhere from several hours to several days to address the concerns. Graphs 1 and 2 on the following page visually demarcate this.

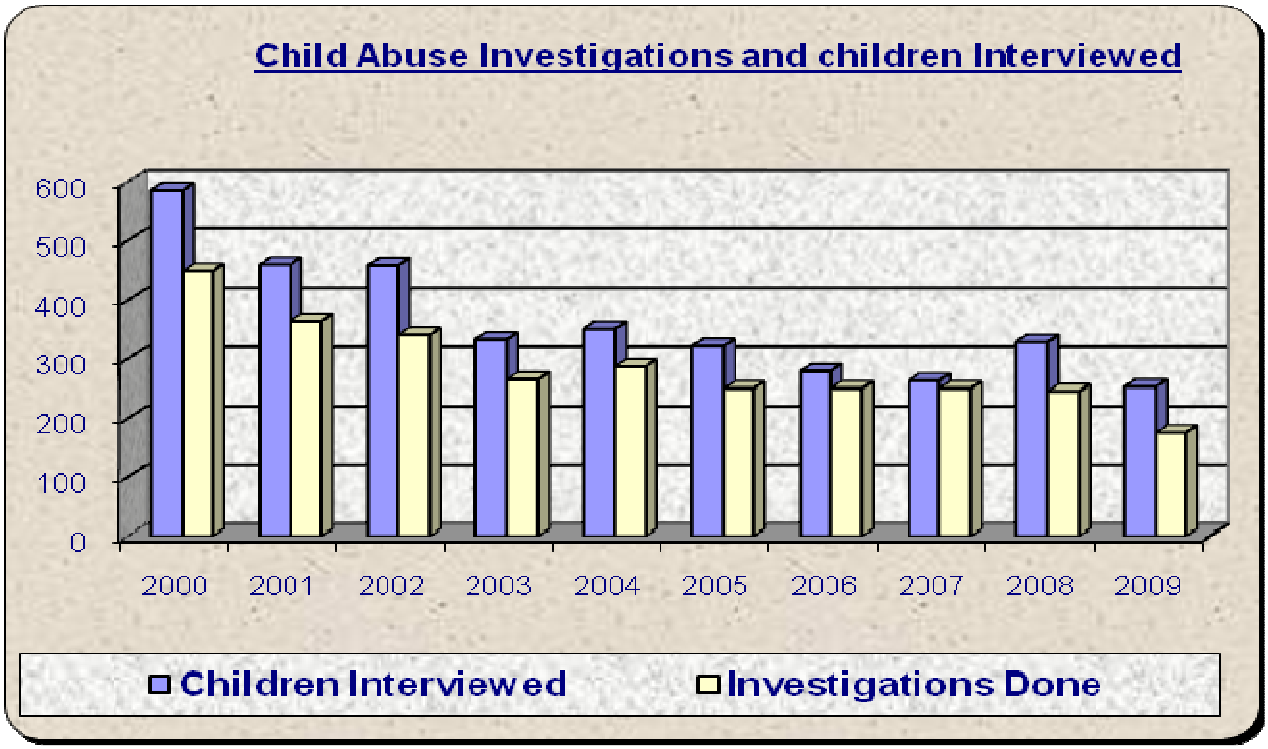
Child abuse records in Wisconsin are registered and tracked in a computer based system known as WISACWIS, (Wisconsin Automated Child Welfare Information System). This system provides a very detailed computerized system for documenting and reporting child welfare referrals and providing on-going services, including out of home placements. The child welfare reports, which generate local reports, are automatically sent to a central statewide database. The overall hope in establishing this system in Wisconsin is to improve child protection and family service programs and to provide a consistent level of family-centered services statewide known as the "Wisconsin Model." In addition to this the second Federal Audit of Wisconsin's Child Welfare System will be occurring in April 2010 which will identify additional needs for training, practice and recording requirements for Wisconsin Counties. Consequently, more time is required on a per case basis to perform the necessary work and to produce documentation of the results both at Intake and Ongoing Work stages. This difficult and time consuming work requires our workers to constantly make judgments that deeply affect the lives of children and their families. These decisions can include removing children from their homes in cases of severe danger, and requesting intervention of the Court. Other cases can involve no action on our part at all. Both types of decisions carry potential benefits and consequences for families and for the Department.

The Department continues to provide a comprehensive child/family treatment program for child abuse/neglect as well as other related family problems. A program manager, supervisor and team of social workers are specifically trained to assist families to improve their lives while protecting children. Additionally, many county-wide collaborative efforts are aimed at improving overall services for families by implementing best practice models. These include the work of the Jefferson County Delinquency Prevention Council, the Jefferson County Wraparound Project, and Dialog for Student Success of Watertown.

GRAPH 1



GRAPH 2



CHIPS Team Mission & Goals

Mission Statement: *Empowering the families of Jefferson County to remain together and keep children safe while drawing on the support of all possible community resources.*

1. Increase the use of evidence based practice that incorporates behavior changes and interventions rather than incident focused/compliance based interventions.

- All case managers utilize the Protective Capacities Family Assessment (PCFA) model to approach both practice and documentation which is a behavior rather than service driven model of practice.
- All case managers utilize the Family Teaming model in combination with the PCFA model in a majority of their cases.
- CHIPS team will promote these concepts by discussing them during team meetings, supervision and staffing of cases.
- All new CHIPS case mangers will be trained on these concepts/models. They will observe other case manger's documentation, family team meetings and home visits.
- CHIPS team will use Protective Capacities Family Assessment language when staffing families and documenting case assessment and progress.
- Learn the Incredible Years material.
- Utilize Incredible Years methods in CHIPS parenting group and family development practices.
- Continue improving knowledge of Emergency Mental Health Services (EMH).

2. Focus on improving safety for the Children of Jefferson County.

- Participate in the one day Safety Booster training through the WI Southern Child Welfare Training Partnership.
- Use CHIPS team meeting time to have "mini" training sessions to ensure transfer of learning. Discussions will be about safety, analyzing and assessing for safety.
- CHIPS team members will use safety language when discussing safety with other professionals, community members, court officials and in documentation.

3. Increase permanency for children and reduce the amount of time children spend in out of home care.

- Schedule regular "superstaffings" for cases that incorporates all county service providers to ensure accuracy of services, reduce overlap of services and monitor both permanency and concurrent planning. Discussion will be held to topics of safety, permanency, services provided and responsibilities.
- Increase the use of EMH services and methods for children and families with mental health needs.
- Train one staff person to have the ability to both case manage CHIPS cases and facilitate Comprehensive Community Services cases.

4. Increase collaboration with community partners to help families achieve their goals and keep children safe in Jefferson County by educating the community and asking them to be a part of the solution.

- Increase the amount of Child Abuse Prevention Month (April) activities each year to continue to promote community awareness and involvement.
- The CHIPS team will accept any invitation to participate in community meetings, initiatives, etc.
- Learn the Incredible Years material.
- Promote Incredible Years model in Jefferson County communities.

Youth Delinquency

Restorative Justice Program

Operated in partnership with Opportunities Inc.
&
Delinquency Prevention Council of Jefferson County

Programs

Teen Court

Since 1998, Teen Court has continued to grow each year, and in total has held 552 youth trials. In 2009, we received 48 referrals for Teen Court. Ten of those 48 referrals were closed before being set for trial for reasons such as family relocation or student disinterest, leaving 38 cases set for trial. Eighteen of those 38 cases were closed successfully and one case was closed unsuccessfully, resulting in a 95% success rate. Nineteen of the 38 cases remain open in 2010.

Participant remarks:

- *"This was my second chance, and I'm not going to forget that anytime soon."*
- *"Being on the jury made me really think about how a person should make up for what they did. I liked that we had to be serious at times, but we could all learn together."*
- *"This was my chance to make up for what I did"*

In 2010, the Teen Court program will implement an enhanced process to further involve youth by utilizing recommended best practices from other teen court models.

Service-to-Community

Since 1997, 1,786 youth have been referred to the service-to-community program and 39,309 hours of service-to-community have been performed in Jefferson County. 1,131 youth have completed their orders successfully, resulting in a 63.3% successful completion rate since 1997. We currently offer 16 different regularly scheduled supervised services-to-community sites for youth to attend across the county, with 12 sites used or open per week on average. In 2009, the 95 youth who were referred completed 1795.5 hours of service-to-community. In 2010, a service-to-community service advancement plan will result in program enhancements to more effectively serve Jefferson County youth with increased success.

Restitution

Since 1996, 588 of the 882 youth referred to pay restitution have successfully completed their court ordered commitments, resulting in a success rate of 67%. Over that time period $235,617.12 has been collected in restitution. Continued collaboration between the Restorative Justice Program, Jefferson County Department of Human Services, and the Jefferson County District Attorneys office, contributed to the successful collection of $7,826.12 in restitution for 2009. This money was collected and repaid to the victims of crimes, in order to compensate for monetary damages caused by the juvenile.

Victim Offender Conferencing

Since 1997, we have held 59 Victim Offender Conferences. In 2009, the Restorative Justice Program received six referrals and found three of those cases to be eligible for conferencing, based upon the eligibility criteria. One of the three conferences used a volunteer victim. The remaining two referrals were closed due to extenuating circumstances (example: family relocation) and an uninterested victim. In 2010, the Restorative Justice Program will continue to work with volunteer victims and encourage uninterested victims to write an impact statement.

Fort Atkinson Probation Program

Beginning in 2005, the Fort Atkinson School District has collaborated with the Restorative Justice Program to provide services to youth who commit alcohol and drug related offenses on school grounds. Since 2005, the Restorative Justice Program has had 47 youth referred to this program for service to community completion and 33 youth referred for ATODA Awareness class completion, for a total of 50 youth served (not all youth receive both sanctions). In 2009, there were 11 youth referred to the Fort Atkinson Probation Program. Only one student was removed from the program by making other arrangements with the school district and the remaining 10 youth successfully completed the program. A positive outcome of 90% program success is reported in 2009.

School-Based Teen Court "Panther Court"

In 2008 this program began in partnership with Riverside Middle School in the Watertown Unified School District.

Panther Court is a school based teen court model, used as an alternative discipline option that links students, teachers and parents. During Panther Court, Riverside Middle School students fulfilled the roles of prosecutor, defense attorney, bailiff and jurors. This program has been labeled by the school as an early intervention program that provides an opportunity for selected juvenile offenders to be questioned, judged and sentenced by a jury of their peers.

The first two Panther Court trials were held on November 24, 2008, and by the end of the school year there were 13 trials held in total. Riverside Middle School identified the types of offenses that were acceptable referrals into the Panther Court program. Of the thirteen cases heard during the 2008-2009 school year, three were for smoking/possession of tobacco on school grounds, eight were for theft, and one was for vandalism/graffiti.

The sentencing options were also guided by staff at Riverside Middle school, as well as completion timelines. It was determined that students sent to Panther Court for sentencing would be given two weeks to complete their obligations, and if done successfully, no further disciplinary action would be taken. Each defendant was mandatorily sentenced to one jury term, where they would be a jury member for the next case and determine a fair and appropriate sentence for that defendant. It was recommended to the jury that in addition to the jury term the defendants receive service to community hours, which could be served in two different settings. The defendants can serve their service to community hours at the Restorative Justice Program sites throughout Watertown, some of which include, cleaning at a local health club, playing Bingo at a nursing home or helping prepare a meal for the disadvantaged at a local church. The other setting which allowed defendants to complete their hours was giving back to their school community. Under the supervision of the custodial staff, many students were sentenced to perform hours after school cleaning. Having both options available to jurors allowed for creative sentencing options, and jurors were encouraged to

apply their critical thinking skills when determining whether or not the defendants should perform their hours in one setting or the other. In total, Panther Court defendants performed 20 service to community hours in Watertown, as well as 12 hours within their school. Other sentencing options included essays, apology letters, or projects. All of the possible options were given to the jury members for a final unanimous decision, with a facilitator on-hand for discussion or questions. It was important to the staff and administration that any sentence that was given to a defendant would not be too much that it would interfere with the already demanding schedules of middle school students.

Of the thirteen cases tried through Panther Court, all of the defendants successfully completed their sentences. Overall the Panther Court program effectively completed the goal of being an early intervention program within Riverside Middle School. The program has continued for the 2009-2010 school year.

Juvenile Drug Treatment Court: Collaboration, Commitment

Since 2005, partners from throughout Jefferson County have been working together to begin a juvenile drug treatment court program. Many hours of research and meetings have gone into making this a reality in Jefferson County, and we are excited to be currently running a juvenile drug treatment court pilot program. There is only one other juvenile drug court in the state of Wisconsin and we are on the cutting edge of this treatment option. Juvenile drug court provides access to treatment services for substance-abusing youth. This court provides a structure for connecting supervision and treatment with ongoing judicial supervision and team management. Efforts include intensive treatment services and supervision with ongoing monitoring and continuing care. There are currently 3 juveniles in the pilot program, all of whom are receiving pro-bono substance abuse treatment services. The treatment team gathers valuable information and experience from each of the participants and each other with the goal of making this program a success. Drug Court sessions are held weekly. These require involvement from the juvenile and their parents as they meet with the treatment team to discuss weekly goals, highs and lows, and participation in an educational activity. The Restorative Justice team has been instrumental in helping to bring this unique treatment program to Jefferson County and has developed invaluable partnerships with the District Attorney's office, Public Defender's office, Human Services Department, Fort Healthcare, Watertown Hospital, Family Resource Associates, Judge William Hue, as well as school districts and volunteer mentors, to work for the betterment of the lives of our Jefferson County youth.

Education Programs

First Offender Program

In 2009, 28 youth were referred to the First Offender Program. Of the 28 youth referred, 23 of them successfully completed the program with a success rate of 82%.

Alcohol, Tobacco and Other Drug Abuse (ATODA) Awareness Program

In 2009, 23 youth were referred to the ATODA program, with four carryovers from 2008. Of these 29 possible participants, three were withdrawn from the class before commencement for a variety of circumstances, leaving 24 possible participants. Of these 24 participants, one case is still open in 2010, leaving 23 youth enrolled in the ATODA class in 2009. Twenty three of the youth enrolled completed this program successfully. This is a 100 % completion rate.

Anger Management

Of the 15 youth referred to the Anger Management Program, five were withdrawn by their case managers before the class began, leaving 10 youth who participated in the class in 2009. Of these 10 referrals, 10 of them successfully completed the class, with a success rate of 100%.

Employability Skills Training

Employability Skills Training began in 2008. In partnership with the Alternative Learning Center in Watertown, it was determined that there was a need to offer an employability skills class, in an effort to assist students in meeting the HSED guidelines. Since it's inception in October of 2008, a total of 46 students have successfully completed this training. In 2009, 32 youth were referred to the Employability Skills Training. Thirteen class sessions and 3 individual meetings were held with students. One student successful acquired employment after completing the training.

Youth Development Activities

Children's Care and Share Fair

The Children's Share and Care Fair started in 2001 and each year has been more successful than the previous year. In 2009, the Fair was held at Fort Atkinson High School on April 4th from 9am-12pm. With a wonderful attendance rate, there were over 225 children between birth and age 11, who received a gift bag filled with coloring books, resources for parents and a healthy snack. Based on a survey, over 100 families attended and 100% of them indicated they would attend next year.

Mentoring Program

The Juvenile Mentoring Program, also known as JUMP, continued to make commitments to match at-risk youth with positive role models throughout Jefferson County. In 2009, eleven youth participated in the mentoring program, spending quality time with a safe adult in the community. In 2009, the JUMP program held three mentoring events, in an effort to provide free and fun activities for mentors and youth to include a food drive, game night and a military greeting card project.

Red Ribbon Week

In 2009, the Delinquency Prevention Council, along with two school districts in the county launched a Red Ribbon Week Social Norms Campaign. Each school district worked with their students to create a social norms poster using the most recent Search Institute data to bring awareness to the false perceptions that exist amongst middle and high school students surrounding alcohol, tobacco and drug use. The posters were printed, distributed and displayed for the entire month of October, promoting the positive message captured in each project.

Internet Predator Prevention Presentation for Youth

On March 12, 2009, the Delinquency Prevention Council hosted Wisconsin Department of Justice/Division of Criminal Investigation (DCI)'s, Special Agent Eric Szatkowski's return to Jefferson County to fulfill the second step of our Internet Safety initiative. Since 1999, Eric has become one of the nation's leading officers in apprehending sexual predators of children who use the Internet to seduce or exploit children. He has been responsible for the arrests of over 150 men from Wisconsin and around the nation, most of whom traveled various distances to have sex with what they believed

to be an underage boy or girl. Eric's arrests also include those who sexually assault children, distribute, possess, and/or manufacture child pornography, and expose children to harmful materials.

In a presentation entitled "The Real World of Internet Predators, Perverts, and their Prey", Eric provided Jefferson County's 7-12th graders with important information that is key to keeping them safe when using the Internet. This presentation shared much of the same information as "The Dark Side of the Internet", which was presented to Jefferson County families in 2008, but in a way that was appropriate for middle and high school students. Students learned from real life examples how to avoid being victimized online, and what to do if something were to happen. They were also shown how the "stranger dangers" they learned about as children are just as important today when they use the Internet, as they become young adults. Most importantly, students learned the risks of making themselves available to predators on the Internet, including advice on social networking sites like My Space and Facebook, and online gaming sites such as X-Box Live.

Victor DeNoble Presentation

In cooperation with the ATODA Partnership, Delinquency Prevention Council of Jefferson County had the pleasure of presenting Dr. Victor DeNoble. Dr. DeNoble was a driving force in the Wisconsin Tobacco Settlement in 1994. On May 4th and 5th, 2009, area 5th and 6th graders heard the turbulent tales of DeNoble's work with tobacco giant Phillip Morris, where he was recruited in the 1980's to develop a heart safe cigarette that would have the same addicting effects of nicotine. DeNoble spoke of his top-secret laboratory on the third floor of the Phillip Morris building where he did brain experiments on rats, a capuchin monkey and a 63-year-old former smoker, and discovered that nicotine changes brain chemistry. Jefferson County students then experienced first hand specimens of the experiments when Dr. DeNoble ran through the auditorium holding the brain of the monkey and then the brain of the 63-year-old former smoker. The auditorium roared with excitement!

After completing his experiments, DeNoble was fired from Phillip Morris, but before he left, he gathered pictures and documents that would prove his laboratory's existence. He sent that proof to the FBI and his testimony before Congress helped lead to settlements forcing tobacco companies to pay billions of dollars and restrict the way they advertise.

Dr. DeNoble speaks to thousands of middle school and college students every year, sharing his message about the dangers of cigarettes and how his research changed the tobacco industry forever, and we were very fortunate to welcome him back to Jefferson County in 2009. Dr. DeNoble is again scheduled in 2010 at address more students in Jefferson County.

Community Development

Parents Who Host, Lose the Most Campaign

In 2009, Fort Atkinson and Watertown communities hosted kickoff meetings for the Parents Who Host Lose the Most: Don't Be a Party to Teenage Drinking. Each event produced excellent community feedback to increase awareness and collectively develop a public campaign to address this issue. It is unfortunate that many well-meaning parents think that it is enough to take away car keys at their teen's parties so the teens won't drink and drive. Parents provide the alcohol or allow alcohol to be consumed based on the false belief that it's a rite of passage, especially during high risk times such as homecoming, holidays, prom and graduation parties. The "Parents Who Host, Lose The Most: Don't Be a Party to Teenage Drinking" public awareness

campaign was developed by Drug-Free Action Alliance in 2000 to educate parents about the health and safety risks of serving alcohol at teen parties and to increase awareness of and compliance with the Ohio Underage Drinking Laws. This fall, the Delinquency Prevention Council will launch a county wide campaign, educating parents about the dangers of hosting underage drinking parties. Our participation in 2010 is expected to increase with continued partnerships with Sheriff's Department, Wisconsin Prevention Clearinghouse, Alliance for Wisconsin Youth and neighboring counties.

In Our Own Backyard: Gangs of Jefferson County

The Gang Committee of the Delinquency Prevention Council of Jefferson County continued to expand their efforts by hosting several parent presentations at local high schools featuring gang specialist Officer Lester Moore of the Madison Police Department. Topics included, general information about gangs, clues that your child may be gang involved, prevention and intervention for families with gang involved youth, and helpful resources for parents. The following school districts participated in the parent presentations: Palmyra/Eagle, Fort Atkinson, and Johnson Creek.

Alcohol Compliance Program

In the fall of 2009, The Delinquency Prevention Council teamed up with the Watertown Police Department to ensure responsible beverage service by developing and implementing an alcohol compliance program for the community. The first step to effective program delivery is education. Beginning in October, 2009 three Bartender Awareness Courses were held that were free of charge to any Liquor License or Bartender License holder in the City of Watertown to ensure that businesses knew the correct way to check state issued identification. Following the community wide training events, alcohol compliance checks began. The alcohol compliance checks involve a person under the age of 21 attempting to purchase alcohol while under the supervision of the Watertown Police Department. The goal is to ensure proper legal practices among liquor license holders and beverage servers.

During 2009, 17 retail locations which included gas stations and convenient stores, were checked. Of the 17 stores checked, 14 remained compliant resulting in an 82% success rate.
In 2010, the Watertown Police Department and community partners will continue to collaborate by maintaining this program in the City of Watertown.

New In 2010

March 2010	~ 9TH Annual Children's Share and Care Fair ~ Gang Summit
April 2010	~ Community Readiness Survey
May 2010	~ Victor DeNoble, Jefferson County school districts ~ Dr. Richard Brown, Substance Abuse – What can Communities and Clinicians do?
June 2010	~ 2nd Annual Youth Leadership Conference

September 2010 ~ Parents Who Host Lose the Most
~ Search Survey

October 2010 ~Red Ribbon Week
~Motivational Productions – Multi-media presentation.

The focus for 2010–2015 through the efforts and community leadership of the Delinquency Prevention Council of Jefferson County will begin shifting from evidence-based principals, practices and programs to environmental prevention strategies. Environmental strategies incorporate prevention efforts aimed at changing or influencing community conditions, standards, institutions, structures, systems and policies. Select strategies have already been identified that will lead to long-term outcomes. These strategies can produce quick wins and instill commitment toward long-term impact on practices and policies within our community. However, it does require substantial commitment from various sectors of the community to contribute to sustainable community change. In 2010, work and momentum will be placed on plan and fund development opportunities to support these efforts.

Delinquency Team

~ The Delinquency Team works closely with the Delinquency prevention Council and provides both juvenile intake and referral to the court system as well as ongoing supervision and case management~

Goals

Our team is looking at a variety of ways to make our unit more effective. We will continue to strive for permanence for our youth and fewer out of home placements. There are several intensive in-home programs available that we will continue to utilize. We also need to keep the community safe and we will continue to focus on that and effective ways to do so. Our team works well together to maximize efforts to provide families with the services and resources that they need.

* Ongoing staff would like to develop and use more community opportunities that are strength based, educational, skill building and provide pro-social exposure for our youth.

A Group Activity Survey form has been developed to track for impact and how many youth have not had a particular experience before. This survey is attached and will make exposure more measurable.

* Ongoing staff will decrease the ewisacwis error rate. The strategy for this is as follows:

1. Carefully check format
2. Make sure entries are made on time
3. Supervisor will check for better quality assurance

* Ongoing is also updating our Delinquency Manual. We want the most current procedures to be documented and available for staff reference.

* INTENSIVE SUPERVISION STAFF are focused on reducing secure detention, respite and placement for youth. Their strategy is to strengthen their use of the following tactics:

House arrest, monitor use, build on strengths/assets, relationship building, and making better choices.

They have also developed a "Questionnaire for Youth on ISP" and a "Questionnaire for Parents of Youth on ISP" to monitor strength and effectiveness of programming. This will assist in making changes where they need to occur. These will be done as youth go off of ISP. These questionnaires are attached and will make effectiveness measurable.

* JUVENILE DELINQUENCY INTAKE STAFF want to measure the risk of reoffending as it relates to our juvenile delinquency population for 2010. This will be accomplished through the use of our Delinquency Risk Assessment Tool which is completed on each juvenile coming through our system with a new referral. The numbers can be compared annually to see how our services are meeting the needs of juveniles in our community. We can compare year to year the juveniles' risk to reoffend. This will be done through the use of a spread sheet which is attached.

Law Enforcement Youth Delinquency Referrals

The following tables and charts provide summary information on referred youth.

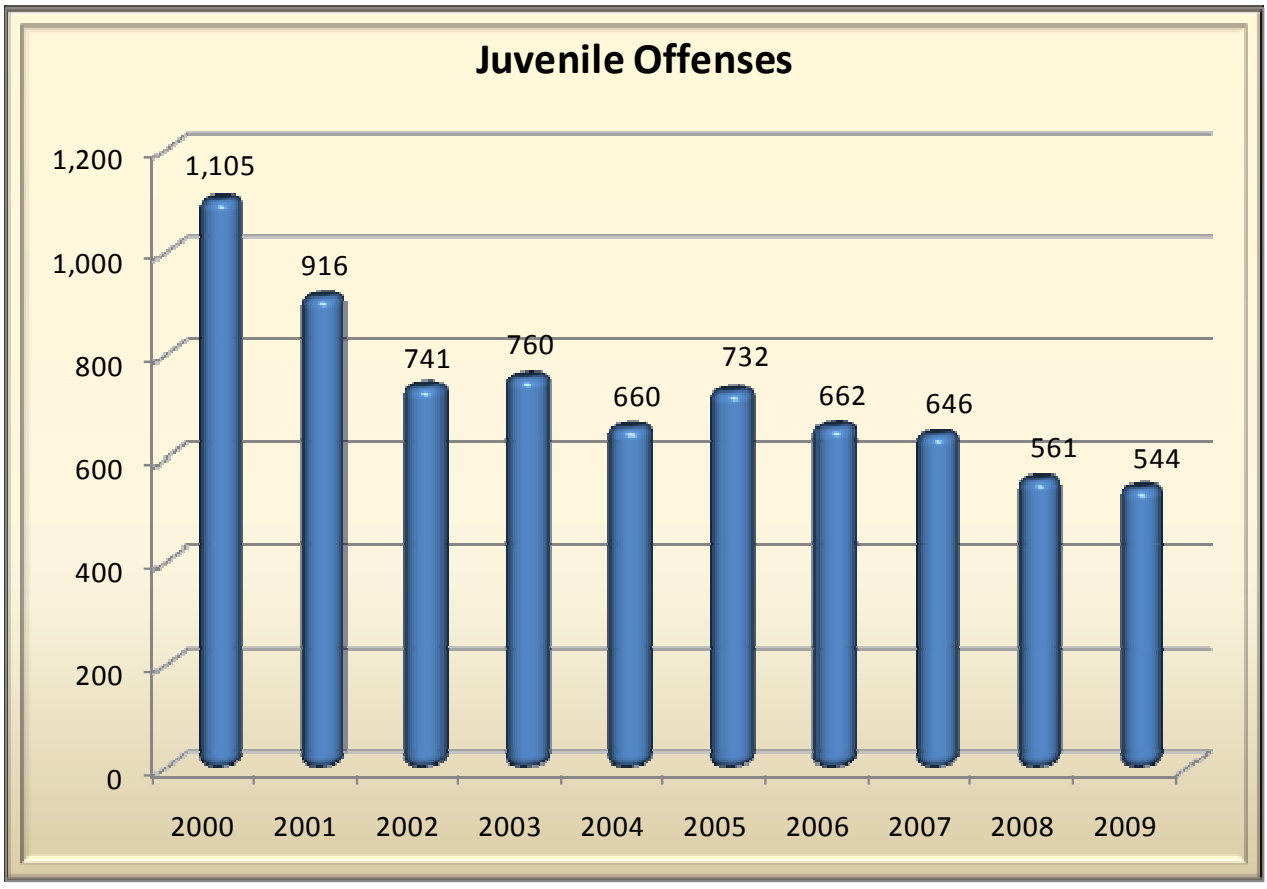
2009 Multiple Juvenile Referrals by Age

		Age <11	Age 11-12	Age 13-14	Age 15	Age 16	Age 17	Total Juveniles per # of Arrests	% of Total
Referrals	**1**	13	13	27	25	37	4	**119**	**53%**
	2-3	2	5	15	26	23	0	**71**	**31%**
	4-5	1	3	3	5	3	0	**15**	**7%**
	6-8	0	0	7	3	2	0	**12**	**5%**
	9+	1	2	4	0	2	0	**9**	**4%**
TOTALS		**17**	**23**	**56**	**59**	**67**	**4**	**226**	**100%**

2005-2009 Juvenile Intake by Age

	Age <11	Age 11-12	Age 13-14	Age 15	Age 16	Age 17	Total Youth
2009	17	23	56	59	67	4	**226**
2008	18	29	91	57	48	1	**244**
2007	10	26	90	47	64	3	**240**
2006	23	30	71	73	73	1	**271**
2005	9	40	98	65	81	10	**303**

Juvenile Offenses									
2000	**2001**	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**	**2009**
1,105	916	741	760	660	732	662	646	561	544



POLICE REFERRALS for JUVENILE OFFENSES

1 and 5 Year Comparisons

OFFENSES	2009	2008	1 Year (2008-2009) Increase/Decrease	2009	2005	5 Years (2005-2009) Increase/Decrease
Alcohol/Tobacco	3	1	**2**	3	2	**1**
Arson	7	3	**4**	7	2	**5**
Battery	28	42	**(14)**	28	33	**(5)**
Burglary/Robbery	50	18	**32**	50	37	**13**
Burning Materials/Fireworks/Explosives	0	1	**(1)**	0	4	**(4)**
Contempt of Court/Violation of Court Orders	1	2	**(1)**	1	11	**(10)**
Crimes Against Children/Other	15	16	**(1)**	15	13	**2**
Criminal Damage to Property	84	30	**54**	84	86	**(2)**
Criminal Trespass	11	7	**4**	11	10	**1**
Disorderly Conduct	141	138	**3**	141	187	**(46)**
Drug Related	51	71	**(20)**	51	100	**(49)**
Fleeing/Escape	5	8	**(3)**	5	4	**1**
Forgery	1	4	**(3)**	1	4	**(3)**
Intimidation/Harrassment	2	5	**(3)**	2	1	**1**
Obstructing/Resisting Arrest	15	30	**(15)**	15	23	**(8)**
OWVWOC/Other Vehicle	5	22	**(17)**	5	30	**(25)**
Receiving Stolen Property	2	2	**0**	2	4	**(2)**
Reckless Endangerment	1	1	**0**	1	9	**(8)**
Sex Offense	20	57	**(37)**	20	21	**(1)**
Theft	53	56	**(3)**	53	97	**(44)**
Truancy	30	34	**(4)**	30	42	**(12)**
Weapon Related	19	13	**6**	19	12	**7**
TOTALS	**544**	**561**	**(17)**	**544**	**732**	**(188)**

- 226 different individuals were referred for a total of 544 offenses in 2009. This reflects a decrease from 2008 of 18 individuals and 17 offenses. The statistics for 2009 show a ten year pattern of decreasing juvenile activity.

- 42% of the total referred youth were 14 or younger.

- 16% of youth were referred four or more times and 9% were referred six or more times.

- 21 youth were referred at least six times and 9 youth were referred nine or more times. This represents an increase in the number of youth who would be considered habitual offenders. This also generally indicates the proportion of youth who require our most intensive services in terms of time and costs. The number of younger youth and youth referred for three or fewer crimes is decreasing.

- Total numbers of delinquency referrals in Jefferson County have continued to decline over the past decade. As noted in prior reports, we believe our contribution to this is the work of the Jefferson County Delinquency Prevention Council which has promoted and emphasized best practice models. This community collaborative work has included prevention, community based work to strenghthen and support families, the work of Restorative Justice Programs as noted above, and the work of the

Delinquecy Team at Human Services, which continues to provide treatment, supervision, and community based work for our most involved youth and their families.

- As reflected in the chart below, while the total number of offenses and referrels for younger youth are decreasing, some of the numbers for serious crimes are rising. Gang activity and the impact of drug use continue to be huge concerns. These indeed are the youth who are more likely to need extended court supervision, intensive services and costly placements that could include corrections. The prevention programs and practices are meeting the needs of the juveniles when caught early. Jefferson County Human Services and the community programs will need to revisit the services that are being provided to serious offenders in an effort to maintain them safely in the community.

JUVENILE CRIMES OF GREATEST CONCERN 2005-2009

OFFENSES	2005	2006	2007	2008	2009
Arson	2	2	5	3	7
Battery	33	32	37	42	28
Burglary	37	30	32	18	50
Crimes Against Children/Other	13	9	7	16	15
Drug Related	100	79	90	71	51
OMVWOC/Other Vehicle	30	29	18	22	5
Sex Offense	21	46	34	57	20
Truancy	42	23	21	34	30
Weapon Related	12	16	12	13	19
TOTALS	290	266	256	276	225

Wraparound

~Wraparound is a comprehensive, coordinated, and community based system of care centered on strengthening the child and family~

The children, youth and families who receive wraparound are typically involved with two or more child and family-serving systems, such as mental health, special education, developmental disabilities, child welfare, and juvenile justice. Other organizations and agencies—including provider agencies and community organizations—may also be involved. Both research and experience has shown that successfully implementing the wraparound process at the team level requires extensive support and collaboration among these various agencies and organizations. For example, the agencies and organizations need to collaborate to provide access to the services and supports that are included in wraparound plans, to ensure that personnel are trained for their roles on teams, to allow staff the time and flexibility that is required to carry out team-assigned tasks, and to monitor the quality of wraparound provided and the outcomes for children and families.

The Jefferson County Wraparound Project provided facilitation services to 56 family teams throughout the year.

Through the team process 158 family members received services.

Through the process 24 of those families' cases were closed:
9 families met their goals and were closed successfully
4 closed due to lack of follow through
4 moved out of County
3 transferred to other services within the County System
4 families indicated they no longer needed to receive the services

Hospitalizations:
16 voluntarily placements were made to a hospital setting for stabilization
4 children were emergency detained to a more restrictive setting.
- 1 child – 3 days
- 1 child – 68 days
- 1 child – 17 days
- 1 child – 5 days

CHIPS
5 youth were in the Foster Care system when the referral was received
- 1 child returned home
- 4 remain in foster care

Delinquency
8 youth were under a Court order:
- 2 expired with no further charges
- 3 continue to receive services with no further charges
- 1 is 17 and has been charged as an adult
- 1 was placed in a group home and subsequently transferred back home
- 1 completed AODA treatment at a residential facility, then moved back home – order expired

Wraparound (CST) Project Goals

1. Increase targeted case management reimbursement of billable time to no less than 80% by being trained in other billable areas:

- Accurately record and bill for emergency mental health time when required.
- Train one Wraparound service coordinator to bill Children's Long Term Support services
- Train Service Coordinators to complete paperwork for Chapter 51 orders and follow the Court procedure to eliminate duplication by county employees and maximize efficiency.

2. Improve permanency and reduce trauma for children by reducing hospitalizations and out of home placements (foster care and residential placements)

Service Coordinators will enter State data citrix system reporting quarterly. This information will be shared with the Coordinating Committee annually.

Project Coordinator will collect out of home placement and hospitalization data reporting. Documentation will be evaluated by the coordinating committee two times a year.

3. Assure quality service coordination of services to families:

- Project Coordinator will complete service coordinator performance review annually.
- Project Coordinator will address areas of need by providing training and feedback to service coordinators in areas of low performance.

4. Evaluate Service Provider Satisfaction by completing the service provider satisfaction survey by April of 2010:

- Results will be shared with the coordinating committee and community providers by December 2010.

Areas of need will be addressed by the Coordinating Committee for quality improvement by December 2010.

5. Provide Wraparound Project Training to:

- JCHSD staff, Law Enforcement, Therapists, Principals, School Counselors, Teachers, Special Education Directors and Staff, other service providers by December 2010

6. Increase participation of families participating on the Coordinating Committee by developing a parent driven sub committee coordinated by Wisconsin Family Ties Family Advocate contracted through Jefferson County Human Services.

- Family Advocate will assure Core Values of Wraparound are being accomplished.
- Family Advocate will complete Parent/Caregiver evaluation annually. Data will be shared with the coordinating committee for discussion and implementation of low ratings.

Wraparound Quality and Fidelity

There is ongoing collection and review of data on the quality of wraparound provided, including live observation, plan review, and feedback from children and families. The methods used to assess quality are grounded in the principles of wraparound. Data is used as the basis for ongoing quality assurance and improvement of the process.

Team Effectiveness Surveys – Service Coordinator (six months)
Youth Services Survey – data is collected through the State (annually)
Service Provider Surveys – Project Coordinator (annually)
Youth Survey – Service Coordinator (six months)
Parent/Care Giver Survey – Family Advocate (annually)
Team Member Closure Survey – Service Coordinator at closure

Early Intervention

~ Early intervention works in partnership with the family to enhance their child's development and support the family's knowledge, skills and abilities as they interact with and raise their child. ~

The Jefferson County Early Intervention Program, established in 1979, has a strong commitment to working with families and staff as a team to provide the best-individualized program for each child.

The Mission of the Program states that they are committed to children under the age of three with developmental delays and disabilities and their families. They value the family's primary relationship with their child.

They work in partnership with the family to enhance their child's development and support the family's knowledge, skills and abilities as they interact with and raise their child.

The Program staff consists of speech and language pathologists, physical therapists, occupational therapists, service coordinators, educational specialists, and a director. Consultations are done with many other specialists to meet the needs of our families.

A child qualifies for services one of three ways. The first and most common way is by a 25% delay in one area based on a normative test. The second way is a diagnosis from a physician. The third way is atypical development as determined by a professional.

GUIDING PRINCIPLES

The following guiding principles direct our planning and program decisions. As the early intervention system grows and develops, its success should be measured by the success with which we are able to realize these principles. The following is a summary of those principles.

- Children's optimal development depends on their being viewed first as children, and second as children with a delay or disability.
- Children's greatest resource is their family. Children are best served within the context of the family. Young children's needs are closely tied to the needs of their family.
- Parents are partners in any activity that serves their children. Parents or primary caregivers have a unique understanding of their children's needs.
- Just as children are best supported within the context of family, the family is best supported within the context of the community.
- Professionals are most effective when they work as a team member with parents and others.

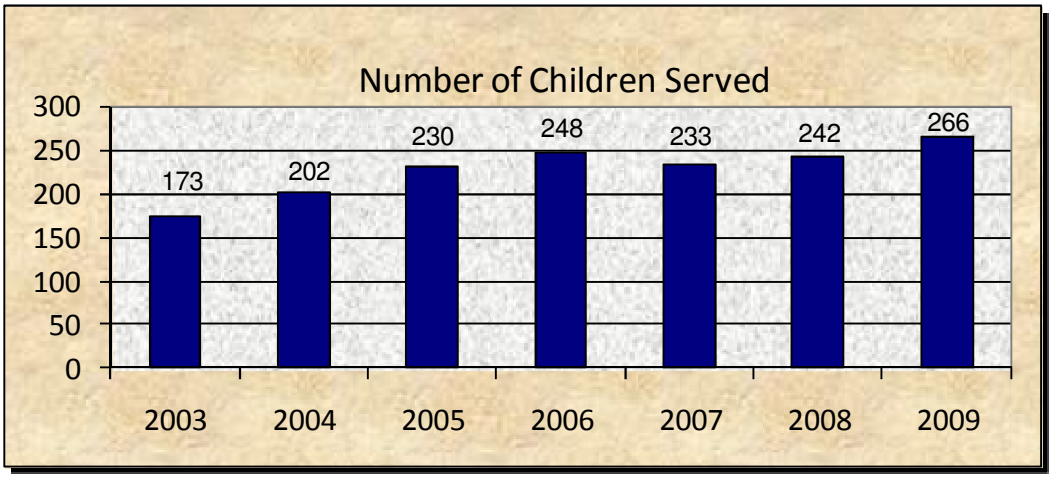
- Collaboration is the best way to provide comprehensive services. No single agency is able to provide all services to all children and families.

- Early intervention enhances the development of children. Early intervention is appropriate for children and families.

After the age of three, a child's education does not end. It is our role to work with the family to find the best "next step" for the child. At 27 months of age, the discussion of transition begins. A service coordinator will discuss the options. A transition meeting will be held with preschools, HeadStart, Early Childhood, and/or a private agency to discuss the needs of the child and family. Transition can be both an exciting time and a very nervous time. We encourage families to visit any of the potential programs. A final planning meeting will be held before the child turns three to determine the family's final decision.

The Early Intervention Program is funded through county, state, federal funds, insurance benefits and the Parental Cost Share. In addition, the United Way of Jefferson County and N. Walworth Counties, Watertown United Way, St. Vincent DePaul, community organizations, and private individuals provide generous support to our program.

The chart and graphs below show the enrollment dating back to 2003. It is very important to remember that Early Intervention services <u>are mandated</u> services; therefore, *a program may not have a waiting list*. Every child that qualifies must be served.



	2003	2004	2005	2006	2007	2008	2009
Total Number of Children Served	173	202	230	248	233	242	266
Number of Referrals	142	156	169	176	144	141	56
Hispanic Families Served	24	25	40	41	39	18	23
Black Families Served	0	0	0	5	3	2	6
Asian Families Served	0	0	3	4	2	2	3
Pacific Islander Families Served	0	0	0	0	0	1	0

Summary Of Data

As shown by the above data, the Early Intervention Program has grown in 2009. The Department of Health and Family Services has not changed the qualification criteria; therefore, we hope the program will continue to receive many new referrals. It is very important to remember that Early Intervention services are mandated services; therefore, *a program may not have a waiting list*. Every child that qualifies must be served.

Birth to Three Goals

Our program will have the following:

1. **High Quality:** A commitment to high quality means that our program will develop policies and practices that are found to build professional skills, including ethics embraced by the fields of child development, family development, and help the community understand the importance of the unique nature of infant and toddler development. Program practices must include awareness of both the opportunities for intervention and the fact that young children are particularly vulnerable to the negative caregiving environment.

2. **Prevention and Promotion:** The proactive promotion of healthy child development and family functioning begins and continues prenatally, upon birth, and through the early years. It is crucial to emphasize the importance of healthy development and detection of developmental at the earliest possible time.

3. **Collaboration:** Collaboration with local community agencies and service providers will maximize the resources available to families of young children in a cost-efficient comprehensive manner. No one program can meet all of a child and families' needs and will build strong alliances within the communities they operate.

GOALS:

A. Increase community awareness and enrollment of Busy Bees Preschool to achieve an increase in enrollment to 80% capacity. (12) twelve children a day. We will be doing more publicity and will promote the preschool within Jefferson County by distributing brochures to appropriate settings such as a library, church, public school and local clinics. New brochures have been completed. We will also host an **Open House** on April 27th and put an ad in the local newspapers.

B. Continue **"Child Find"** activities under DHS 90. Our goal to participate in two more awareness activities in the community during the year. This could include: parade, fairs and presenting to other community agencies. This will be funded in part from the ARRA Grant. We will have a banner made and other informational/promotional items to give out to the public.

C. Continue to provide service coordination to our families to ensure that families have access to all resources. The program will have 80% billable time. This will be monitored by the EDALS and QA reviews.

D. To have three team members: Diane Bazylewicz, Tonya Buskager and Karen Brunk be an active part of the **Incredible Years Team** to learn the new curriculum and implement it within the program and with our families. We will start training with the team on April 7th and have meetings two times a month.

Busy Bees Preschool

~ Busy Bees Preschool provides a positive learning experience through a fun-filled morning with a structured routine and consistent behavioral limit. ~

The Busy Bees Preschool is a preschool for two and three year old children that opened in September of 2005. It offers two morning sessions; Session One is Mondays and Wednesdays and Session Two is Tuesdays and Thursdays. Both sessions run from 8:30 am to 11:00 am. The preschool runs from September to June for up to 12 children each day. The population is a combination of community members and children enrolled in Birth to Three.

The Preschool provides developmentally appropriate activities in a seasonal thematic manner. The content of the day is presented through a consistent routine. The activities emphasize language and concept development through free play, music, finger plays, books, gross and fine motor activities, art experiences, and daily living skills, which will include a snack time and a bathroom routine. These activities address all developmental domains and incorporate quiet and active time. The snack is provided by the preschool and includes at least two food groups based USDA guidelines.

Units are planned in advance so that families receive a unit letter to promote follow through in the home setting. Materials will cover diverse themes and cultures. Families are encouraged to share their experiences and cultures in order to educate children about the diversity of our population.

Busy Bees Preschool provides a positive learning experience through a fun-filled morning with a structured routine and consistent behavioral limit. Children will increase their self-esteem and confidence through understanding and succeeding at our preschool. In cases of unwanted behaviors, the staff will redirect and use positive reinforcement to encourage positive interactions. If unwanted behaviors persist, the family and staff will develop a behavioral plan.

The Preschool has become incredibly popular and has increased its services to offer a summer session for five weeks during July and August. The Busy Bee Preschool utilizes the Wisconsin Model Early Learning standards for all lesson plans and will achieve academic, social, and developmental standards.

Child Alternate Care

~A major goal of Alternate Care is returning people to their natural home and community setting by providing a wide variety of mental health and social services.~

Our Alternate Care services provide access to a wide range of out-of-home placements for children and adults. Alternate care remains a very important priority service and great care is taken in making these placements. Placements are made with the intention of assisting the child to return to his or her home setting. When this is not possible, long-term placement arrangements, such as group homes, may be provided. Individuals who need out-of-home placement require a great deal of social work time, effort and funding in order to successfully return to community living.

Alternate Care Philosophy

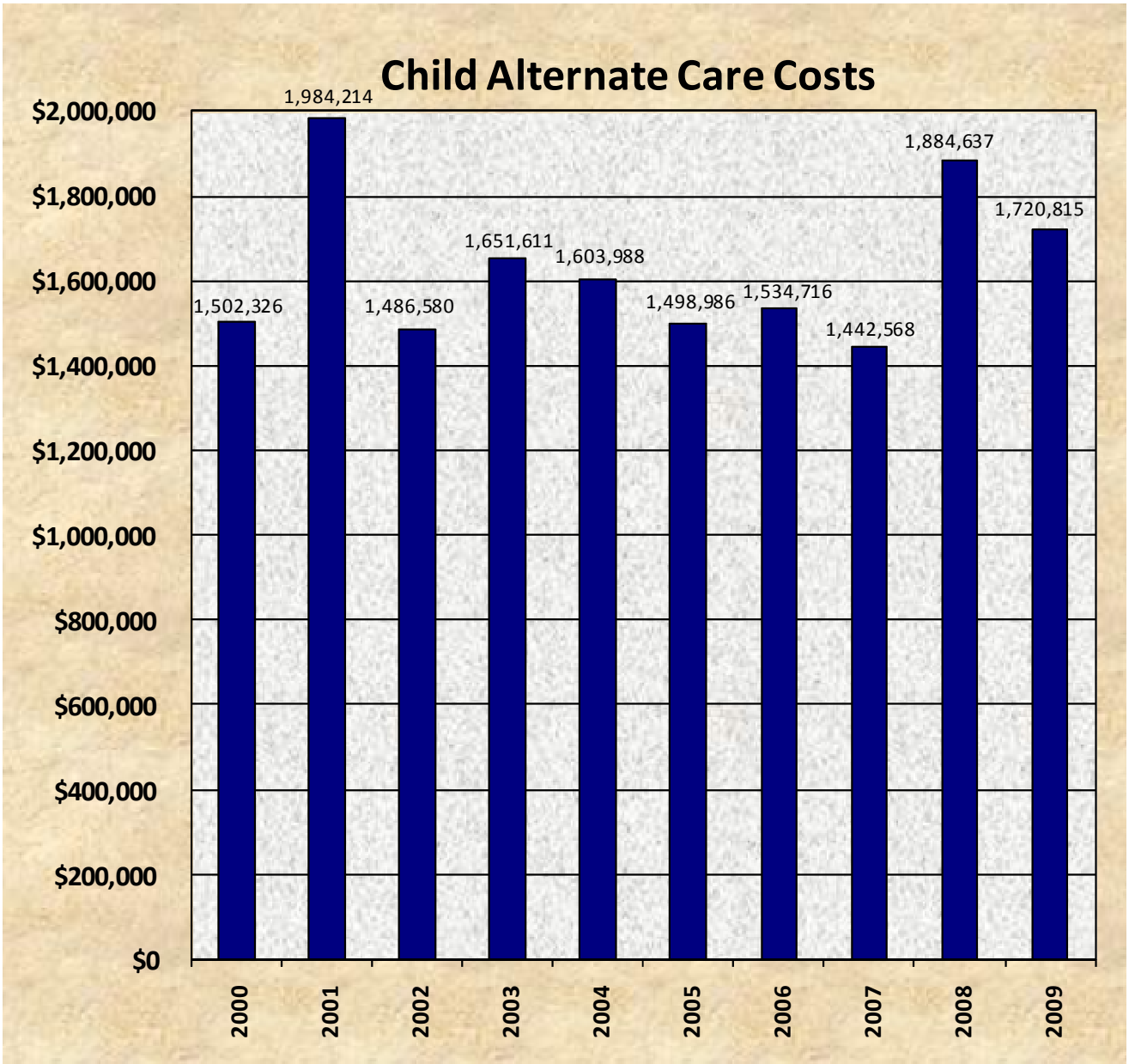
- Avoiding placements, particularly of children, whenever possible, by providing protection, support and services.

- Keeping placements short in duration and making them within the community whenever possible.

- Minimizing the use of institutional placements by creating packages of community services, including operating our own group homes.

Child alternate care costs remain a major concern to us, and a priority for new, increased and changed programming. The graph shown on the next page tracks the costs in this area for the past 10 years. The 2009 Child Alternate Care costs decreased from 2008 by more than $100,000. This can be attributed to the increasing efforts of the staff to focus on prevention, teaming and the development of informal supports when working with families. Five new county foster homes were licensed to provide care for children in 2009. These local homes allow the children to remain closer to their family and community. Family interaction happens more frequently and children are able to return home sooner. Numbers of youth placed did increased slightly, but the length of time in placements is shorter with the average length of stay for Jefferson County children is less than 11 months in comparison to the state average of 16 months. A number of these placements can still be attributed to an inter-county transfer of ten children late in 2007 that carried through 2009. From time to time changes such as this, which are not in our control, occur. Additionally, as noted above, our use of out - of - county and residential treatment centers continues to be higher than average, which generally means that these youth in question have higher needs for structure and treatment. That said we are acutely aware that we need an increased focus on youth placements from treatment needs and cost perspectives. Increased use of programs including Comprehensive Community Services and Wraparound as well as stabilization beds will continue to be considered for youth and their families in the Child Protection and Delinquency areas as these families come to us with significant mental health needs.

January 1, 2010 will bring new foster care licensing legislation for foster homes and kinship care homes in response to continued child fatalities throughout Wisconsin. All homes that have children placed through a court order need to be licensed as foster homes including kinship care homes. The licensing now includes four levels of care with kinship homes being licensed as a level one foster home for specific child/children. This has increased the workload for the foster care coordinator and the other staff within the children and family division particularly around training and ongoing foster parent support.


Child Alternate Care Costs
$2,000,000
$1,800,000
$1,600,000
$1,400,000
$1,200,000
$1,000,000
$800,000
$600,000
$400,000
$200,000
$0
1,502,326
1,984,214
1,486,580
1,651,611
1,603,988
1,498,986
1,534,716
1,442,568
1,884,637
1,720,815
2000
2001
2002
2003
2004
2005
2006
2007
2008
2009

Detention Placements

A final related statistic in the Child Alternate Care area is our use of secure detention (locked juvenile jails) for youth. During 2009, 68 youth were placed in these facilities at a cost of $42,015. This is a substantial decrease from 2008 when 108 youth were placed at a cost of $64,269. These placements are either made by the Juvenile Court or by Human Services staff in order to provide community protection or to sanction youth for violation of a court order.

COUNTY	NUMBER OF PLACEMENTS	TOTAL COST
Dane	0	$ -
Eau Claire	0	$ -
La Crosse	2	$ 1,050.00
Outagamie	0	$ -
Ozaukee	0	$ -
Racine	2	$ 660.00
Rock	61	$ 39,270.00
Sauk	0	$ -
Washington	3	$ 1,035.00
Waukesha	0	$ -
TOTALS	**68**	**$ 42,015.00**

The following chart shows 121 youth from Jefferson County were placed in some form of out-of-home care during 2009, which is an increase of 28 youth from 2009. Some required more restrictive placements in institutional settings. However we continue to take strong measures to avoid these. Because the needs of persons who require alternate care are high, programming efforts, particularly mental health services, to meets these needs, are used in conjunction with placements.

ALTERNATE CARE PLACEMENTS - CHILDREN								
PROGRAM	**2004**	**2005**	**2006**	**2007**	**2008**	**2009** Male	**2009** Female	**2009 Total**
Foster Care (In-County)	**24**	**30**	**28**	**46**	**25**	13	21	**34**
Foster Care (Out-of-County)					**14**	4	9	**13**
Treatment Foster Care (In-County)	**6**	**12**	**7**	**7**	**2**	4	5	**9**
Residential Care Center (Child Care Institution)	**17**	**7**	**5**	**8**	**8**	8	5	**13**
Child Correctional	**4**	**3**	**1**	**1**	**1**	1	0	**1**
Child Mental Health Institute	**4**	**4**	**3**	**4**	**2**	2	0	**2**
Out-of-County Treatment Foster Home	**11**	**12**	**21**	**22**	**27**	20	13	**33**
Out-of-County Group Homes	**17**	**23**	**17**	**12**	**14**	9	7	**16**
TOTALS	**83**	**91**	**82**	**100**	**93**	**61**	**60**	**121**
BREAKDOWN								
Black				**10**	**9**	5	3	**8**
White				**87**	**73**	51	52	**103**
Hispanic				**0**	**8**	5	0	**5**
American Indian					**1**	0	1	**1**
Asian						0	1	**1**
Native Hawaiian/Other						0	1	**1**
Unable to determine				**3**	**2**	0	2	**2**
TOTALS	**83**	**91**	**82**	**100**	**93**	61	60	**121**

Children's Waiver

~ The goal of this team is to assist children with disabilities and their families remain together and safe in their own homes and communities by providing them with individualized services to meet their needs.~

The children's long term support team provides services to children who are eligible for Medical Assistance and have met the criteria as developmentally disabled, physically disabled or are severely emotionally disturbed. These children can be served through the children's long term support waiver or the family support program. These are programs that allow for assessment of the children and family needs and a supporting plan for the provision of services. The services that may be funded include; counseling, therapy, daily living skills, day services, home modifications, respite care, special medical or transportation services, case management and supported employment. Unfortunately there is a cap on this funding source which leads to a waitlist. In 2008, forty six children were served by long term care waivers. In 2009, fifty nine children were served by children's long term care waivers.

Independent Living

~To help young adults become independent, responsible and productive members of society when they reach adulthood~

The Independent Living Program is a partially Federally sponsored program for young adults in placement to help them enhance personal daily living skills that will help them become independent, responsible and productive members of society when they reach adulthood. This is a mandated service for any child placed outside of their home who is 15 years or older. Each eligible youth in out-of-home care must have an Independent Living Skill Plan that addresses life skills development based on an independent living skills assessment. The ILTP must be incorporated into the permanency plan which is reviewed and updated every six months (at minimum). Youth expecting to age out of care after the age of 17 years must each have an ILTP that concentrates on their transition from out-of-home care; identifies ongoing independent living needs and outcomes, and describes how ongoing independent living needs will be met. Youths must participate directly in the assessment and development of their plan goals and activities; and accept the personal responsibility for gaining skills and independence.

The plans, services and activities should address, but are not limited to, the following areas:

- High school education, post secondary education or training
- Career planning and employment
- Safe and stable housing
- Transportation
- Health and medical
- Knowledge/use of community resources and support systems
- Financial self-sufficiency
- Home maintenance
- Obtainment of documents including but not limited to birth certificate, social security card, State ID, and immunizations
- Youth's self goals

The Independent Living Transition Plan and activities should include:

- Measurable goals and objectives
- Experiential training for youth where possible
- Identification of community resources available and utilized
- Identification of life-long family/adult connections

BEHAVIORAL HEALTH DIVISION

The Behavioral Health Division is organized into four areas:

- Mental Health & Alcohol and Other Drug Abuse Clinic, which all provides intoxicated Driver services
- Community support Program
- Comprehensive Community Services
- Emergency Mental Health

Mental Health/Alcohol and Drug Outpatient Clinic And Intoxicated Driver Program

~ Participants of the program are assessed for strengths and needs; the principles of hope and empowerment are integrated into the clinic service~

THE PROGRAMS

The Mental Health, DHS 35/Alcohol and Other Drug (AODA), DHS 75 Outpatient Clinic serves adult Jefferson County residents with mental health and substance abuse concerns. In 2009 files for 128 new mental health consumers were opened to the Mental Health clinic. The files of 456 AODA consumers were opened, including all the individuals who came for driver safety assessments. The clinic provided mental health services to 381 individuals and substance abuse services to 226 individuals.

Participants of the program are assessed for strengths and needs; the principles of hope and empowerment are integrated into the clinic service. A treatment plan is created using the consumer's own strengths and resources to increase their potential for leading the life they want. Services are provided in the least restrictive setting; decreasing the disruption of the individual's life while still providing for recovery.

The clinics employ: six full-time staff with master's degrees in Social Work, Counseling or Psychology, one of whom works part-time in the jail, two full-time staff certified as Alcohol and Drug Counselors, a Community Outreach Worker and a full-time intake worker.

Due to a tremendous increase in emergency mental health services one of the master level clinicians was assigned to provide emergency mental health back-up. This was increased as the year progressed to a three quarter position crisis work and quarter time clinician. It is expected in 2010 to increase to a full time crisis worker.

All staff were trained in trauma informed care. Staff viewed the two day state conference on trauma via the web. A review of the clinics policies and forms was undertaken to ensure compliance with trauma informed care.

The clinic is also responsible for overseeing civil commitments and in many cases, providing treatment for the individual. Under WI § 51, persons who are assessed to be dangerous to themselves or others and have a mental health disorder may be detained involuntarily. If the court determines that these persons need to be treated, they are placed under an order for treatment, usually for 6 months. The person can seek treatment

from the clinic, or if the person has other resources by another area provider. The clinic (the 51.42 board representative) is responsible for supervising the commitment period and insuring that the individual is following through with the treatment recommendations regardless of where treatment occurs.

The Intoxicated Driver Program is mandated under HFS 62. Each county is responsible for establishing and providing assessments of drivers ordered by the court and development of a driver's safety plan based on the completed assessment. The clinic has two IDP assessors who provide all IDP assessments and driver's safety plans for Jefferson County. In 2009 the IDP program completed 436 assessments and driver's safety plans.

Consumer Satisfaction

In 2009 the Outpatient Clinic conducted a consumer satisfaction survey. The ROSI (Recovery Oriented System Indicators) measures the satisfaction of the participant and the degree to which its services are recovery oriented. We had thirty two respondents, out of the 120 surveys sent; a 27% return rate.

The survey asks 42 questions regarding the participant's experiences in the past six months. The choice of responses range from strongly disagree to strongly agree and includes an option of does not apply to me. The questions rates 6 areas of service: Person Centered Services, Barriers to success, Empowerment, Employment, Staff Approach and Basic needs.

Survey Discussion

In all areas of service except employment, percentages strongly endorsing a more positive and recovery oriented experience increased from 2008. The Employment service area showed a sharp decline in consumer satisfaction. The employment area was negatively impacted by the statement "Mental Health services helped me get or keep employment". Staff do not offer supported employment services to consumers; they are referred to community resources for assistance.

In 2009, a larger percentage of respondents felt they had good service options to choose from at the clinic and that staff had up-to-date knowledge on the most effective treatment. In the service area of empowerment, over 90 percent of respondents strongly endorsed they were treated with respect, were listened to carefully and had complete information in understandable language before giving consent to their treatment.

	LEVEL OF RECOVERY ORIENTATION					
	High		Mixed		Low	
	2008	2009	2008	2009	2008	2009
Person Centered	72.2%	93.3%	18.2%	3.3%	9.1%	3.3%
Empower	75%	81.3%	25%	15.6%	-	3.1%
Employ	54.5%	20 %	36.4%	60%	9.1%	20%
Basic Needs	50%	60 %	30%	24%	20%	16%

	Low		Mixed		High	
	2008	2009	2008	2009	2008	2009
Barriers	8.3%	6.7%	83.3%	43.3%	8.3%	50%
Staff Approach	50%	-	33.3%	6.9%	16.7%	93.1%

2009 Goals

- **Increase consumer choice by increasing the number and type of services.**

The clinic increased the groups offered to consumers in 2009. Groups offered included, depression, anxiety, anger management, and grief. The substance abuse groups were redesigned. Persons were offered options based on where they were at in the process of change for their substance use.

- **Use of evidence-based treatment modalities.**

Groups offered through the clinic used curriculum and interventions shown to be effective through clinical trials.

- **The Intoxicated Driver Program will become self funded.**

The two primary assessors completed 430 assessments. The senior employee was out on medical leave from September to the end of the year. The second assessor completed 248 assessments; enough to reimburse his wages and benefits.

- **Quality assurance and Quality Improvement.**

All groups were required to have a pre/post test to show the impact of participation in the group. Quality Assurance will continue in 2010 with quality assurance being integrated into clinical collaboration when opening and reviewing a consumer with the supervisor and medical director.

- **Development of a training program to address new and current employee training needs.**

Jefferson County Training Blog provides all employees with access to web-based training for mental health and substance abuse providers. Other in house training included on-going emergency mental health training and training in the mental status exam and trauma informed care.

- **Monitoring productivity of staff.**

Staff's productivity was monitored weekly. Staff was responsible for achieving an 80% consumer service average.

- **Outpatient clinic policy and procedure manual will be updated.**

The outpatient mental health policy manual was updated to reflect the changes in the administrative code. Both the substance abuse and Intoxicated Driver policy and procedure manuals will be updated in 2010.

2010 Goals

- **The outpatient clinic will continue to address the increased demand for services.**

The clinic will continue to address the on-going need of members of the community for its services. As the need continues to rise, the clinic will continue to improve its services and to effectively meet the needs of those individuals who have no other resources.

Community Support Program

~CSP has been successful in helping consumers meet their goals and enhance the quality of their lives in the most cost effective manner~

The Jefferson County Support Program was developed in December of 1996 and began receiving clients in January 1997. This Community Support Program was certified on June 1, 1997 and is certified under HSS 63 as a Community Support Program. The program was audited by the state in May 2008 and was recertified for two years at that time. It will again be audited this May.

In its twelfth year of operation the Jefferson County Community Support Program provided services to 132 consumers ranging in age from 10 to 75. These consumers had mental health diagnoses such as schizophrenia, schizoaffective disorder, bipolar, major depression and various anxiety disorders. In 2009, 20 consumers were admitted and 14 were discharged.

Jefferson County Human Services CSP has grown significantly. In 1998 it served less than thirty consumers, and employed five and a half staff. In 2009 the CSP staff consisted of a CSP Director/Clinical Coordinator; psychiatrist/medical director; program assistant; part time secretary; two full time and one part time mental health technicians one of whom was also a peer support specialist; one vocational specialist; one part time nurse; and eleven case managers/CSP professionals. One case manager position remained unfilled throughout the first third of the year.

Community Support Programs in the state of Wisconsin have an extensive and well researched history. The original CSP started out of Mendota Mental Health Institute in the 1980's and is now known as ACT. The ACT model has received numerous awards from the American Psychological Association for its research. It is now used on a nationwide and international basis to advance the mental health services for people with a severe and persistent mental illness. It has proven effective for reducing symptoms, hospital costs, and improving overall quality of life. The research has shown that for outcome measures to be similar for consumers in other CSP's it is important to have as much fidelity to the ACT model as possible. Jefferson County CSP continues to have very high fidelity to the ACT model and the team functions as an ACT team. It is believed that this led to better outcomes for our consumers.

In accordance with the ACT model, the Jefferson County CSP has the capacity to function as a mobile in-patient unit. The program provides psychiatric services, symptom management, vocational placement and job coaching, supportive counseling, opportunities for social interactions, individual and group psychotherapy, medication management and distribution, education and money management and budgeting, coaching in activities of daily living, including how to maintain a household and homemaking skills, crisis intervention, case management and supportive services to people with severe and persistent mental illness. All consumers in the CSP, at some time, have had acute episodes that have resulted in the need for frequent psychiatric hospitalizations and emergency detentions to institutes for mental disease. Consequently, in the past, their lives were disrupted and they were removed from their community of choice. Presently, CSP services can be titrated up and down quickly as the need for more intensive treatment arises.

Jefferson County's CSP also provides consumers the evidence based practices (please see sections below for detail) of Illness Management and Recovery, Integrated Dual Diagnosis groups for those with substance abuse issues, Supportive Employment, Family Psychoeducation, Seeking Safety, and Dialectical Behavior Therapy. Consumers also are encouraged to complete Wellness Recovery Action Plans; these plans specify what is helpful for the person in a crisis situation and function similar to a psychiatric directive.

It is believed that due to these combined efforts the Jefferson County CSP was successful in helping consumers meet their goals and enhance the quality of their lives in the most cost effective manner.

Some of the specific accomplishments for the year 2009 include:

1. **Two consumers moved from alternate care placements, i.e. supported apartments, or adult family homes, to their own apartments.**

2. **Seven consumers, who were on Chapter 51 orders, successfully completed their court requirements.**

3. **One consumer resumed managing their own money as their skills were enhanced and the protective payeeship was dismissed.**

4. **Only five consumers were admitted to an Institute for Mental Disease, i.e. Mendota Mental Health Institute. Four were new emergency detentions.**

5. **Thirty four percent of consumers worked in a job of their choosing. Four of these consumers worked full time and do not receive social security benefits.**

6. **Seventeen consumers served the community through volunteer work at such places as Fort Atkinson Memorial Hospital, St. Vincent's, Touched by a Paw, Headstart, CSP consumer council, and Horizons Drop In Center.**

7. **Six consumers pursued educational goals. Four attended UW Whitewater, one attended Herzing College, and one pursued an online program to become a veterinary assistant. One of these consumers graduated in May with a bachelor's degree and is returning the UW to pursue his Master's degree.**

8. **All goals were met from last years report. These will be reviewed below in detail.**

There were nine program goals established for 2009.
Goal number one: Train all staff in Trauma Focused Cognitive Behavioral Therapy and begin to implement this with consumers.

All case managers completed the online training for Trauma Focused Cognitive Behavioral Therapy. Three staff attended the state's training on Trauma Informed Care. Attention was paid to trauma focused issues in conducting assessments with new consumers and developing new treatment plans with those consumers already established in the program. In 2010, staff will be further trained in Trauma Informed Care and ways to implement it in the CSP will be identified.

Goal number two: Update the CSP policy manual
The CSP policy manual was updated with current forms and procedures. This will be utilized to train three new staff in 2010.

Goal number three: Increase our implementation of evidenced based practices and continue to monitor our fidelity to them throughout the year. Offer a Family Psychoeducation and Integrated Dual Diagnosis Group.

This goal encompassed advancing our implementation of the evidence based practices and monitoring our fidelity to them. We completed fidelity scales for each of the evidence practices for 2009. A fidelity scale indicates how accurately you adhere to the true model. We did not complete consumer interviews in doing these fidelity scales. We did review charts, discussed with the person providing services, and the program supervisor.

2009 Evidence Based Practices Summary

1. **ACT Fidelity score: 123**

Our CSP team continues to function as an ACT team. Each item is 1, not implemented at all, to 5, fully implemented. We rated a 2 in two areas. One area we rated low in was our nursing hours. We only have eight hours with over one hundred consumers at this time. There are no plans to address this currently. The second area involves the number of consumers we have attending monthly treatment groups for dual diagnosis. We did run a dual diagnosis group for consumers with both mental health issues and alcohol and drug issues. Four people completed this group. We have taken on several consumers over the past year, that have a dual diagnosis. Many of these individuals are currently in the pre-contemplation stage for dealing with their substance abuse issues. The team continues to use motivational interviewing techniques to work on enhancing their motivation for treatment.

2. **Illness Management and Recovery. Fidelity score: 53**

We offered this as a group for the past three years. The group was facilitated by a peer support specialist and a clinician. Five members participated in the group. The group had good retention and all individuals completed the group. Pre and post measures indicated that group members felt at the end of the group that their understanding of their mental health issues was enhanced and were able to identify more coping techniques. The team has also over the past year worked on completing the Illness Management and Recovery curriculum in whole or in part with a number of individual consumers. New admissions to the CSP are encouraged to complete the curriculum. Two issues were rated threes. The first involves using the complete curriculum with each person involved. At times, if the person is doing it individually and has had symptom management courses in the past only selected sections are utilized. The second issue involves using cognitive behavioral techniques in most sessions.

3. **Dialectical Behavior Therapy**

A DBT group was offered in 2009. This teaches consumers skills in Mindfulness, Interpersonal Effectiveness, Emotion Regulation, and Distress Tolerance. No significant data was identified from reviewing the functional screens. The group retention rate was good and four people completed the group.

4. **Family Psychoeducation**

We attempted to conduct a family psychoeducation group at several points again in 2009. We were not able to get enough appropriate referrals to run a group. In many cases, it is difficult for an individual interested in the group to find a natural support person willing to make the commitment for the group. In 2010, we will attempt to utilize the Family Psychoeducation material on an individual basis with families of consumers.

5. Integrated Dual Diagnosis Fidelity score: 59

In 2009 a relapse prevention group was offered. We continued to use motivational interviewing and approached treatment in stage-wise interventions. We work as a multidisciplinary approach with time-unlimited services. We offer pharmacological treatments and promote health and wellness. We continue to be low in the percentage of people with co-occurring disorders who participate in both treatment and self-help groups. Four people completed the Dual Diagnosis Group. One individual moved from the pre-contemplation stage to the contemplation stage in pursuing treatment for his mental health and substance abuse issues.

6. Supported Employment Fidelity score: 108

Our CSP and CCS team has one employment specialist, who is fully integrated into the mental health treatment of consumers. The employment specialist does have small caseload size, and is a generalist, completing all phases of vocational services. Employment searches occur in an individualized manner with a permanent, competitive job being the goal. Some people have to wait for services because of delays with DVR, but a rapid job search is attempted. In 2009, the job search began even before DVR services were established with some consumers. Supports follow the person and occur in the community. The vocational specialist now spends the majority of his time providing vocational supports and no longer regularly does EMH. This person does not have a case management caseload.

In 2009, there continued to be an individual dedicated to providing vocational services to CSP and CCS consumers. This individual was able to devote more time to assisting consumers in pursuing their vocational goals since he is no longer doing other tasks. This program followed the evidenced-based model for supported employment developed by Dartmouth College. In spring, 2009 all staff attended a day long training offered by the individual from Dartmouth. The supported employment program also served as a vendor for individuals that were in the CSP, and were referred by the Department of Vocational Rehabilitation (DVR). As a vender of DVR services, the vocational specialist provided services related to vocational assessments, job placement, job coaching, benefit analysis, and job shadows, and assistance in arranging transportation.

Consumers receiving vocational support learned job skills to obtain and keep employment. They learned these skills through individual sessions and through experience with employers. Vocational assessments were provided. Providing a job experience for consumers allows them to explore vocational interests, observe the skills needed for the position, and learn an employer's expectations.

Many of the consumers served by the vocational program gained or maintained employment. With the consumers already working, fifty one consumers had employment at some time throughout the year. This led to 38.6 percent of CSP consumers working; this exceeds the national average of people working who have a psychiatric disability. Some of the places of employment were at nursing homes, group homes, supported apartments for people with disabilities, restaurants, cleaning at a wayside, peer support specialists through human services, convenience stores, a tire supplier and a spa. The positions that were filled in the community were: grounds maintenance, dishwashers, , CNA, nail technician, golf course worker, custodian, group home worker, drivers for people with disabilities, a person who changes oil, taxi cab driver, sales assistant, human resources manager and dietary aide. Other consumers remained employed through Opportunities, Inc. until they could find community employment.

Furthering education continues to be a focus of the CSP vocational program. A total of six consumers from the CSP attended post high school programs in 2009. One consumer attended UW-Whitewater for marketing and completed a BS in May. Another attended for Psychology. A third consumer is at UW-Whitewater pursuing a degree in education. The final consumer at UW-Whitewater is attending for political science. One attended Herzing College, pursuing a degree in computer networking. One attended MATC to work toward becoming an English teacher. The final consumer receiving educational support at the CSP is working on an online program

to be a veterinary assistant. Depending on what the person wanted and needed, CSP staff helped people register for classes, coordinate services with the student disability services, obtain financial aid, manage their symptoms while in classes and provide transportation to school.

A success story for 2009 included one consumer that was able to work his way up in a company and is now doing human resources. Four individuals in the program were able to work full time over the past year. One of these individuals graduated from the program.

In summary, CSP consumers have achieved their employment goals by following the evidence-based model of supportive employment for people who have a severe mental illness. The percentage of CSP consumers working in the community at their goal jobs exceeds the nationally reported average.

Goal number four: Support our consumer council in their self identified goal of running more fund-raisers.

The consumer council did run two fundraisers in 2009, a chili luncheon and a bake sale. In the middle of the year, the council struggled since several of the officers had health concerns that precluded their continued involvement. In November of this past year, all consumers were invited to attend a meeting to discuss how to recruit more people for the council and to plan the holiday party. Thirteen consumers attended. In 2010, an attempt will be made to reinvigorate the consumer council through offering additional staff support.

Goal number five: Utilize the county web site for training our new staff member and ongoing training for current staff.

Two staff members were hired in 2009. One began working in May and the other started at the very end of December. The web-site was utilized to train staff in areas such as basic recovery principles, motivational interviewing and trauma informed care. Two additional staff will be hired in 2010. The web site will be continue to be utilized to assist in the training and development of these new staff.

Goal number six: Regularly update the mental health database and run quarterly reports to identify problem areas and implement interventions as needed.

An emphasis was placed on staff providing the program assistant with information so the data base could be routinely updated. The CSP director began recording the number of treatment plan goals when reviewing the treatment plan reviews for quality. Reports were run and information was utilized to develop quality assurance projects described below. In 2010, information will be identified in team meetings and will be reported directly following the meeting to the program assistant.

Goal number seven: Continue a Quality Improvement initiative by evaluating data, developing projects, and implementing plans.

We again decided to implement the Recovery Oriented System Inventory (ROSI). The ROSI is the result of a research project that included consumers and non-consumer researchers and state mental health authorities who worked to operationalize a set of mental health system performance indicators for mental health recovery. The ROSI was developed over several phases with a focus group of consumers who were able to develop a 42 item self report adult consumer survey. A factor analysis resulted in the domains of staff approach, employment, empowerment, basic needs, person centered, and barriers being able to be measured. The ROSI was found to be valid and reliable over the three phases of implementation.

Consumers of the CSP were sent a ROSI survey to complete anonymously. Fifty three consumers completed this survey down from fifty five last year. The following charts further explain the ROSI and summarize the results. The questions associated with scales 2 and 5 are worded negatively, so a lower mean is seen as more positive.

Means and Percentages for ROSI Consumer Survey Scales

	ROSI Overall Mean	Scale 1 - Person Centered	Scale 2 - Barriers	Scale 3 - Empower	Scale 4 - Employ	Scale 5 - Staff Approach	Scale 6 - Basic Needs
Average for All Consumers	3.4	3.5	1.7	3.4	2.8	1.3	3.3
% w/ Mostly Recovery-Oriented Experience	78.0%	81.6%	54.9%	77.4%	52.0%	91.1%	86%
% w/ Mixed Experience	22.0%	18.4%	43.1%	20.8%	36.0%	8.9%	9.3%
% w/ Less Recovery-Oriented Experience	0.0%	0.0%	2.0%	1.9%	12.0%	0.0%	4.7%

Note: Means can range from a low of 1.0 to a high of 4.0. However, item wording for the shaded scales are negatively phrased, so a low mean represents a more recovery-oriented experience (meaning the consumer disagreed with the negative statements.) The percentages in Rows 3-5 have been adjusted for Scales 2 and 5 so they have the same meaning as the other scales.

The means from 2009 were virtually identical from those of 2008. These results continue to indicate that consumers feel empowered by CSP staff and person centered planning occurs. Further, consumers report liking the approach of staff and find that the barriers to seeking services they need are minimized. The employment scales reflects that more people are interested in working.

The team identified that we would try to improve our treatment plan goal completion percentage over the course of the year. In team meetings, attention was paid to goals that people were working on and ways to meet these goals. In the first six months of the year, the treatment plan goal completion rate was only 63.7%. We were able to increase that to 77% in the second half of the year. The average for the year was 70.6%.

Goal number eight: Create a system to review the quality of documentation at the CSP.
Clinical coordinator reviewed all treatment plans and reviews before they were filed. Attention was paid to goals and objectives being measurable and person centered. It was discussed that we would begin staffing treatment plans in team meeting again as has been done in the past to get more input from other staff as well.

Goal number nine: Monitor and track staff productivity by reviewing DARS.
Each week staff turned in a monitoring form to supervisor detailing their number of billable hours versus those actually worked. This was calculated and reviewed with supervisor and staff. A standard of eighty percent billable hours was encouraged. In November the DAR process became electronic. Computer reports can now be generated to detail the percentage of billable hours for each staff. For the last month and a half of 2009

the electronic monitoring revealed that seven of eleven staff billed over the eighty percent mark, with an average of seventy eight percent among all eleven staff.

Goals for 2010

1. Further train all staff in Trauma Informed Care and implement this along with the Trauma Based Cognitive Therapy in the CSP.

2. Increase our implementation of evidenced based practices and continue to monitor our fidelity to them throughout the year. Offer a Dual Diagnosis Group, Illness Management and Recovery, and begin implementing Family Psychoeducation individually with consumers and their families.

3. Increase staff support to reinvigorate our consumer council and assist them in recruiting more individuals to take an active role on the council.

4. Train and develop three new case managers at CSP by utilizing the training site and sessions with CSP director to hone clinical skills required at CSP.

5. Develop a more efficient system to ensure that the mental health data base is updated with all required fields. Run it quarterly and review in team meeting to identify areas that need to be addressed. Monitor treatment goal percentage by case manager throughout the year to ensure quality assurance.

6. Continue a Quality Improvement initiative by evaluating data, developing projects, and implementing plans.

7. Utilize the new EDAL system to monitor and track staff productivity weekly.

Comprehensive Community Services Program (CCS)

~ CCS services reduce the effects of an individual's mental health and/or substance use disorders; assist people in living the best possible life, and help participants on their journey towards recovery ~

The Jefferson County Comprehensive Community Services Program (CCS) completed its third full year. First certified in February 2006, Jefferson County's CCS program was granted a two-year license in March 2007. This license was renewed on February 20, 2009 for two years.

Program Description

CCS is a voluntary, recovery-based program that serves children (0-18), adults (18-62) and senior citizens (63-100) with serious mental health and/or substance abuse disorders. As stated on the State's, Bureau of Mental Health Prevention, Treatment and Recovery website, CCS services reduce the effects of an individual's mental health and/or substance use disorders; assist people in living the best possible life, and help participants on their journey towards recovery.

CCS offer an array of psychosocial rehabilitative services which are tailored to individual consumer. These services include: assessment; recovery planning; service facilitation; communication and interpersonal skill training; community skills development and enhancement; diagnostic evaluations and specialized assessments; employment related skills training; physical health and monitoring; psycho education; psychosocial rehabilitative residential supports; psychotherapy; recovery education and illness management; and additional individualized psychosocial rehabilitative services deemed necessary.

General data

During 2009, 73 consumers ranging in age from 5 to 80 received services. This is an increase of 12 consumers from last year. Throughout 2009, 23 new consumers were admitted and 20 consumers were discharged. Of the consumers admitted to the program, 10 were children and 13 were adults. Of the consumers discharged, 4 were children and 14 were adults. Consumers had diagnoses of: schizophrenia, schizoaffective disorder, bipolar, major depression, borderline personality disorder, post-traumatic stress disorder, various anxiety disorders, and substance use disorders.

The CCS staff consists of a Psychiatrist/Medical Director and a CCS Service Director. There are currently four CCS Service Facilitators, and a full time job developer. One of our goals has been to maintain staff within the program so we can create a stable program offering consistent services to people. We have been accomplishing this as the program has one full time service facilitator that was hired in 2006 and two more that were hired in 2007. The CCS Service Director has been with the program since 2006.

Consumer Satisfaction

The CCS program conducted a Recovery Oriented System Indicators (ROSI) consumer survey to measure the consumer satisfaction of our program and how recovery oriented we are. We had 12 adult respondents this year. Below is the means and percentages table which breaks the survey down into the following categories: overall mean, person centered, barriers, empowerment, employment, staff approach, and basic needs. The barriers and staff approach categories are negatively phrased and a lower number in these areas shows the program and staff is doing well in these areas. The mean for both of these was 1.5 or below which is what we would like to see. The highest scoring area was in staff approach which consumers rated that 100% feel that

they had a mostly recovery oriented experience. This is an increase from last years rating of 94.1%. Another area worth noting is the overall mean, which measures the overall recovery oriented experience, of the ROSI. In 2009 it was rated at 90.9%, in 2008 82.4%, and 58.3% for 2007. As noted each year our percentages increase due to staff retention and training in recovery concepts.

The two areas we continue to target are employment and basic needs. These continue to be our lowest percentage areas on the ROSI survey. In the employment area we really started to focus on supported employment in September 2008. We started with a part time job developer. In 2009 we increased this to a full-time position. This has been helpful in developing positions in the community and working with consumers in CCS. Consumers respond well and enjoy working with this person. This is confirmed by the ROSI data which shows an increase in percentage of people reporting they are experiencing a mostly recovery oriented experience. In 2009 71.45% reported that they had a mostly recovery oriented experience, compared to 53.8% in 2008, and 45.5% in 2007.

The second area, basic needs, is difficult for our program to improve upon as there are two questions in this category which address; 1. Do they have enough money to live on? 2. Do they have affordable housing? We continue to do our best to connect people to services which can be of some assistance to them but our program has no control over their income or housing costs.

Means and Percentages for ROSI Consumer Survey Scales

	ROSI overall mean	**Scale 1 person centered**	**Scale 2 Barriers**	**Scale 3 Empowerment**	**Scale 4 Employment**	**Scale 5 staff approach**	**Scale 6 Basic needs**
Average for all consumers	3.4	3.6	1.5	3.4	3.1	1.2	2.6
% with mostly recovery oriented experience	90.9%	90.9%	72.7%	90.9%	71.4%	100%	40.0%
% with mixed experience	9.1%	9.1%	27.3%	9.1%	28.6%	0.0%	50.0%
% with less recovery oriented exp	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	10.0%

To track how well our program is serving youth and families we used the Youth Services Survey. A survey is sent to the youth participating in the program and another is sent to a family member and/or support person. This survey asks about satisfaction of services, involvement in choosing services, availability of needed services, how staff treated the youth and their family, and finally whether they feel life has improved as a result of services.

Below are some quotes from family members/support people from the surveys they returned. In total 6 people responded.

What has been most helpful thing about services you and your child received over the last six months?

- "I have had a better understanding of her diagnosis, medication, and how I can handle situations."
- "Keep doing a good job, Holly Pagel does an amazing job."
- "Having Heather meet here at the house."
- "Open communication with the team."
- "I believe there has been a great deal of support for my daughter and myself."
- "The social worker my daughter has is great, she listens and tries new things for us."
- "Case manager listens to our needs.
- "Services decreased as the need went down, I appreciate the flexibility."
- "Their concern and willingness to help with problems when they arise."

Below are quotes from the five youth that responded to the question, what has been the most helpful thing about the services you received over the last six months?

- "It has taught me a lot about dealing with life and I though it was great to have the availability of talking to people when needed."
- "Gave me someone to talk to."
- "I get along with my sister."
- "The group home they put me in."
- "I am better at sharing my feelings."
- "The fact that someone is there if needed, someone to talk to."
- "That my team has stuck by me no matter what."

Monetary benefits

In 2009 the CCS program billed $792,257.10 and was reimbursed from Medicaid $466,517.73. The program was able to bill $346,353.65 more in 2009 than in 2008. The increase in our billing is a direct result of having four full time service facilitators and being able to admit more consumers to the CCS program.

Children

In 2009, the CCS program served 26 children, ages 5 to 17; of these children, 14 were males and 13 were females. Nineteen of the children resided at home, three lived in treatment foster care, one child lived in foster care, and two children lived in a residential child care facility. During 2009 seven children had a mental health commitment order, with one child being able to end their order. Two young adults were employed and five others were seeking employment.

In 2009, 10 children were admitted to CCS and 4 were discharged. Of the four discharged, one child no longer met the requirements of the program through the children's functional screen assessment, one chose to withdraw from the program, one child moved out of county, and one child was admitted for an undetermined period of time to a residential child care facility.

Of the 26 children that CCS served throughout 2009, 4 of them were admitted for psychiatric hospitalizations. Three of the four were admitted voluntarily to the hospital for a total of 30 days. One child was returned, either to Winnebago Mental Health Institute or Mendota Mental Health Institute, under criteria of their chapter 51 mental commitment order for a total of 112 days.

Adults

In 2009, the CCS program provided services for 46 adults aged 18-62. Of these adults, 16 were males and 30 were females. Six adults resided at an adult family home, 28 lived in their own home/apartment, and five people lived in supported apartments. One person moved from an adult family home to a supported apartment, one person moved from a group home to a supported apartment, 3 people moved from adult family homes to their own home/apartment, and two people moved from supported apartments to their own home/apartment. A total of 5 people moved out of placement into their own apartments. Two adults had a guardianship and mental health commitment order and 5 adults had only mental health commitment orders. One adult had just a guardian.

In 2009, thirteen adults were admitted to CCS and 17 were discharged. One consumer was transferred to a more-intensive program, (CSP) due to increased symptomology and the need for additional services. Seven consumers were successfully discharged out of county services and receive their supports and services in the community from providers and/or natural supports. Seven consumers felt they didn't need the supports of the CCS program and transferred services to other programs. Two consumers passed away.

Between 15 adults there were: 193 hospital days, 162 Mendota/Winnebago/IMD days and 317 Lueder Haus/crisis stabilization days were used. Seven adults accounted for the IMD days and of those 7 adults two of them accounted for 87 days. Eleven adults comprised the voluntary admissions to hospitals and 7 adults were admitted to the Lueder Haus/crisis stabilization bed with one person totaling 181 of the 317 days.

Elderly

In 2009, the CCS program served one 81 year old male. This person lived in an adult family home and had a guardian. He passed away in February 2009.

Recovery Plans

Consumer recovery plans are reviewed every six months. Thirty-eight consumers participated in the CCS program long enough to have two plans in 2009. Overall, 65% of their goals were met. Seven consumers were able to meet 100% of their goals in 2009. The children met 66% of their goals. The adults met 63% of their goals. We continued to use person centered planning when doing recovery plans. This approach to conducting the meeting and writing the plans has had a positive response from consumers, family members, contracted providers, and natural supports. Consumers have reported feeling in charge of their services and being able to direct the team in their needs. Family members and providers feel that they can easily read and understand the plan. Family members and other natural supports feel more connected as they are written into the plan providing services to the person. The plans also inform the consumer of the services they are to receive. This increases accountability since everyone on the team knows his or her responsibility in assisting the consumer in building recovery.

Additional service providers

In 2009, the CCS program contracted with nineteen providers.

- Two residential providers, who coached and taught consumers the skills needed to move into their own home or apartment in the future.

- Seven agencies provided contracted therapy services. These agencies provided a mix of in-home and agency individual and/or family therapy.

- CCS had 2 contracted psycho-social rehabilitation workers. One rehabilitation worker served as extra support for children and was especially helpful to children in foster care.

- Five peer support specialists assisted the CCS program last year. These trained peers provided support and advocacy for persons in their journey of recovery.

- Three individuals were contracted to provide therapy/service facilitation services.

As residential providers, therapists, psycho-social rehabilitation workers and peer support specialists employ psychosocial rehabilitation practices; their services were billable to Medical Assistance through the CCS program.

2009 Trainings

On March 2, 2009 CCS team and the coordinating committee held a guided reflections session with Molly Cisco and Dianne Greenly to improve upon services for our CCS program. In April of 2009 the CCS service director and two CCS service facilitators began training in Functional Family Therapy. This is an evidenced based practice in working with families to decrease risk factors and increase protective factors. Studies have shown that this type of family therapy reduces recidivism in the Juvenile Justice system and helps keep families together. The CCS team offered trainings throughout the year for foster parents and residential support staff. We found this beneficial in getting foster parents and residential providers to understand the philosophy of recovery and to know that people do recover and can live independently in the community. The team also completed the Trauma Focused CBT training on line. We also completed the Supported Employment training for staff and consumers using the Dartmouth Model. Focus of the training was on the implementation techniques and fidelity of the model.

Trainings will continue to be offered in the area of mental health, AODA, and recovery for consumers and providers. We will continue to do outreach within the community to expand the knowledge of CCS and the services it provides.

2009 Evidenced Base Practices

CCS worked in partnership with the CSP to offer the following evidenced based practice groups; Illness Management and Recovery, Supported Employment, and Integrated Dual Diagnosis. The Seeking Safety group was offered to adolescents, women, and men. The women's group was facilitated by a CCS service facilitator and a female peer support specialist.

Fidelity scales were completed for each of the evidence practices for 2009. A fidelity scale indicates how accurately you adhere to the true model. Consumer interviews were not conducted in completing these scales and that will be addressed in 2010. We did review charts, and had discussions with the person providing the treatment, with the program supervisor, and with the division manager.

- Illness Management and Recovery. Fidelity score: 60
  This group was offered by CCS last year and was held at Horizons drop in center in Fort Atkinson. The group was facilitated by a CCS service facilitator and a female peer support specialist. Four people attended this group from the CCS program.

- A woman's seeking safety group began in September of 2009. Pre and Post measures are being utilized along with a fidelity measure to monitor adherence to the model. Currently seven women from the CCS program are involved in this group. The group is facilitated by a CCS service facilitator and a female peer support specialist. This is an integrative treatment approach for PTSD and substance abuse. This group provides tools and techniques to teach "safe coping skills".

- CCS implemented a seeking safety group for adolescent girls over the summer of 2009. Initially the group started with eight girls. Three of them completed the entire curriculum. Pre and Post measures were utilized and it was found that the girl's coping strategies for dealing with their symptoms of PTSD were increased.

- Five of the CCS families began participation in Functional Family Therapy. Pre and Post measures are conducted with these families and the information will be available for 2010.

- A DBT group was offered in 2009. This teaches consumers skills in Mindfulness, Interpersonal Effectiveness, Emotion Regulation, and Distress Tolerance. No significant data was identified from reviewing the functional screens. The group retention rate was good and four people completed the group.

- Supported Employment Fidelity score: 108
  Our CSP and CCS team has one employment specialist, who is fully integrated into the mental health treatment of consumers. The employment specialist does have small caseload size, and is a generalist, completing all phases of vocational services. Employment searches occur in an individualized manner with a permanent, competitive job being the goal. Some people have to wait for services because of delays with DVR, but a rapid job search is attempted. In 2009, the job search began even before DVR services were established with some consumers. Supports follow the person and occur in the community. The vocational specialist now spends the majority of his time providing vocational supports and no longer regularly does EMH. This person does not have a case management caseload.

  In 2009, there continued to be an individual dedicated to providing vocational services to CSP and CCS consumers. This individual was able to devote more time to assisting consumers in pursuing their vocational goals since he is no longer doing other tasks. This program followed the evidenced-based model for supported employment developed by Dartmouth College. In spring, 2009 all staff attended a day long training offered by the individual from Dartmouth. The supported employment program also served as a vendor for individuals that were in the CSP, and were referred by the Department of Vocational Rehabilitation (DVR). As a vender of DVR services, the vocational specialist provided services related to vocational assessments, job placement, job coaching, benefit analysis, job shadows, and assistance in arranging transportation. Consumers receiving vocational support learned job skills to obtain and keep employment. They learned these skills through individual sessions and through experience with employers. Vocational assessments were provided. Providing a job experience for consumers allows them to explore vocational interests, observe the skills needed for the position, and learn an employer's expectations. Eleven CCS consumers were involved with supported employment in 2009. Currently 7 consumers are employed and two consumers are furthering their education.

CCS Coordinating Committee

The CCS Coordinating Committee is currently comprised of consumers, staff, and community members. The committee meets every other month for one hour. The meetings are held at Horizons drop in center in Fort Atkinson. Elections were just completed for the board positions for the next two years. The officers are; President – Heidi Knoble, Vice President – Kathy Cordio, Secretary – Katie Pytier, and Treasurer – Ryan Miller.
The CCS Coordinating Committee is submitted the following recommendations for the CCS program in 2010.

- Expanding and defining the role of the Peer Support Specialist. Developing a job description and identifying and providing appropriate and specific training for the position.
- Starting a Seeking Safety group for adult males

- Purchase the Incredible Years material and partner with schools to implement the curriculum among teachers, providers, and parents.
- Facilitating training called Navigating Systems for parents regarding school systems and how to access and utilize services provided.
- Continue to communicate with school districts and meet with them to educate them on children's mental health and what services the CCS program can provide.
- Expanding the children's section of the CCS Program through the admission's process as well as contracting more therapists that work with children for necessary services.
- Problem-solving concerns regarding wait times prior to appointments with service facilitators, peer support specialists, therapists, and psychiatrists to encourage timely services.
- Developing a Suggestion Box for the CCS Program so that input can be collected on a continual basis to assist in improving the program.
- Encouraging further education by facilitating groups that would visit area technical colleges and universities to gather information and encourage peer to peer support.
- Making flyers available within the Jefferson County community to inform residents of the CCS Program and services offered.
- Having a peer introduction meeting in a social setting to allow for further networking amongst consumers participating the in the program.

The CCS Coordinating Committee would like to thank you for your consideration regarding these recommendations. We look forward to another successful, productive and recovery focused year.

Sincerely,
Heidi Jo Knoble
Peer Support Specialist and President of the CCS Coordinating Committee

Review of 2009 Program Goals

1. Update the CCS policy manual
   Policy manuals are updated with new forms and will continue to be updated as needed changes are made.
2. Increase the implementation of evidenced based practices and continue to monitor our fidelity to them throughout the year.
   We continue to implement evidenced based practices discussed above in group settings and we also use Heartmath, Trauma Focused CBT, Coping Cat, Functional Family Therapy, Seeking Safety, and DBT on an individual basis.
3. Continue to utilize the county website for training of staff, consumers, and contracted providers.
   This has become part of the training requirement for obtaining CCS training hours. This website is shared with contracted staff also.
4. Create a quality improvement team of staff and consumers to evaluate data, develop projects out of the data, and come up with implementation plans.
   We continue to look at ways to improve the CCS program and services that are offered through the program. We look at our ROSI data and listen to feedback from consumers and from the CCS coordinating Committee.
5. Clarify through the state data base portal which consumers are in CCS when updating the Mental Health AODA functional screens. This will help us get data for quality improvement projects and to track how the program is doing.
   This portal continues to be updated and will be completed in 2010. The CCS team will be updating it each time a new consumer comes into the program.

6. Implement a quality improvement project looking at why the alternate care costs have increased and how to effectively decrease those costs.
   We have been more cognizant of the costs of placements and the needs of consumers. In setting rates with providers we are looking at what thy provider will do to assist the person towards independence and what the CCS team can provide as supports to that person. We are writing providers into recovery plans and keeping them accountable for the services that they are to provide. The team also looks at what skills the person needs to achieve in order for them to be independent. When those skills are attained the team immediately assists the person in finding independent living arrangement. We also have been able to set up supports for young people moving out of their family member's home or a foster home so they may move into their own apartment and be independent.
7. Implement Functional Family Therapy (FFT) with children 11-18 years of age and their families. This is evidenced based and is proven to keep children out of residential placements and detention facilities and in the home.
   In April 2009 the CCS service director and 2 service facilitators started the FFT training which will conclude July 15 & 16, 2010. We will then be a certified FFT site with Walworth County Human Services. Currently 10 families have been or are in the process of FFT. Currently we have outcome summaries for two families. Both of these families have reported positive change in communication skills, adolescent behavior, parenting skills, parent supervision, family conflict, and family change. To learn more about FFT go to www.fftinc.com.
8. Implement Coping Cat and Trauma Focused CBT workgroups to start providing these therapies to CCS consumers.
   All CCS staff have been trained in Coping Cat and Trauma Focused CBT and these therapies are being implemented in individual sessions.
9. Provide trainings to foster homes, treatment foster homes, and group homes for children in regards to the CCS program and the residential support benefit. This will assist us in recouping money for children who are placed out of the home. The skills that the providers will teach the children will help them to enter back into the home sooner.
   Some training has been done with the foster homes and group homes. There needs to be more done in this area. We are implementing the The Incredible Years, an evidence based practice, to teach parents, foster parents, children, and teachers new skills.

Goals for 2010

1. Improve data collection by working with state staff to make sure our CCS consumers are identified in their data collection and analysis procedures.
2. Continue to utilize the county website for training of staff, consumers, and contracted providers.
3. Provide trainings to foster homes, treatment foster homes, and group homes for children in regards to the CCS program and the residential support benefit. This will assist us in recouping money for children who are placed out of the home. The skills that the providers will teach the children will help them to enter back into the home sooner.
4. Reduce the number of children hospitalized and placed out of the home. In order to do this we will implement the Incredible Years and work to improve treatment by continuing to offer:
   - Love and Logic
   - Stop think and act
   - Children's WRAP plan
   - Seeking Safety
   - Coping Cat
   - Trauma Focused CBT
   - Functional Family Therapy

5. Continue to offer peer supports as part of our service array.
    - Initiate the statewide description of what a peer support specialist is and what they do.
    - Offer ongoing trainings for peer supports in documentation, boundaries, recovery, advocacy, and writing WRAP plans.
    - Facilitate the state certification.
6. Maintaining the fiscal responsibility
    - Increase the EMH billing within the CCS program.
    - Keeping billable hours at 82% each week.

Training Goals for 2010

- Implement Incredible Years workgroups to start providing these therapies to CCS consumers.
- Ensure all Peer Support Specialists attend the state certification training.
- Trainings for foster homes and group homes in regards to the CCS program and the residential support benefit.
- CCS staff to attend substance abuse training.
- CCS staff will all be trained in trauma informed care.

Emergency Mental Health

~ Individuals receive crisis assessments, response planning, linkage and follow up, and crisis stabilization services~

Our Emergency Mental Health (EMH) crisis intervention services were certified under HFS 34 in October of 2007. In May of 2008, as part of the outpatient mental clinic certification, we received certification for two more years. In becoming certified, the Department did not have to add any new services or new staff. The Department did have to organize procedures, formalize policies, develop billing systems and train staff across the entire agency. EMH procedures and policies were reviewed by nearly all staff in the Behavioral Health and Child and Family Division. Almost all staff in both of these divisions completed the required orientation and training to deliver EMH services and to bill Medicaid for these services.

In 2009 we saw an unprecedented need for our Emergency Mental Health services. The number of crisis contacts increased from 995 in 2008 to 3582 in 2009. These people received crisis assessments, response planning, linkage and follow up, and crisis stabilization services. Of the crisis assessments completed, 248 were in response to suicide calls. One hundred forty one of these callers were able to be assisted in the community with services from our clinic staff, which include psychiatry, medication, and counseling, and with support from friends and family. The remaining suicide calls resulted in 107 emergency detentions. This is a very impressive number of people who are suicidal being diverted away from an acute setting state hospital. Please see graph which reviews Mendota and Winnebago net costs over the years. An additional ninety nine diversions occurred for people who were not hospitalized. This occurs because Human Service intake workers complete a Crisis Assessment and make the decision about the need for an emergency detention. It works because we have mental health professionals and a psychiatrist who are able to see people with acute symptoms on the same day and then follow them closely. This system, which we have used for over twenty years, is being replicated across the state.

In the 2009, the second full year of certified Emergency Mental Health services, we billed $493,464 for our services. We received payment for $235,281. In 2008 we received $60,505 in reimbursement for our EMH services.

Lastly, one hundred eleven people were served by the Lueder Haus, our crisis stabilization facility. In 2008, 84 people were served. This is a 34% increase.

Consumer Satisfaction

This year, to evaluate consumer satisfaction with our Emergency Mental Health services, we randomly chose consumers of EMH services to complete the ROSI. The ROSI is the result of a research project that included consumers and non-consumer researchers and state mental health authorities who worked to operationalize a set of mental health system performance indicators for mental health recovery. The ROSI was developed over several phases with a focus group of consumers who were able to develop a 42 item self report adult consumer survey. A factor analysis resulted in the domains of staff approach, employment, empowerment, basic needs, person centered, and barriers being able to be measured. The ROSI was found to be valid and reliable over the three phases of implementation. It is used in many mental health programs across the country.

The following chart explains the ROSI and summarizes the results. The questions associated with scales 2 and 5 are worded negatively, so a lower mean is seen as more positive.

Means and Percentages for ROSI Consumer Survey Scales

	ROSI Overall Mean	Scale 1 Person Cente	Scale 2 - Ba	Scale 3 - Emp	Scale 4 - En	Scale 5 - Approach	Scale 6 - Needs
Average for Consumers	3.1	3.2	2.0	3.2	2.4	1.3	2.5
%w/mostly Recovery-Oriented Experience	58.3%	75.0%	46.2%	80.0%	50.0%	100%	40.0%
%w/ Mixed Experience	41.7%	8.3%	38.5%	20.0%	33.3%	0.0%	30.0%
% w/ Less Recovery-Oriented Experience	0.0%	16.7%	15.4%	0.0%	16.7%%	0.0%	30.0%

Note: Means can range from a low of 1.0 to a high of 4.0. However, item wording for the shaded scales are negatively phrased, so a low mean represents a more recovery-oriented experience (meaning the consumer disagreed with the negative statements.) The percentages in Rows 3-5 have been adjusted for Scales 2 and 5 so they have the same meaning as the other scales.

These results indicate that consumers feel empowered by EMH staff and person centered planning occurs. Further, consumers report liking the approach of staff and find that the barriers to seeking services they need are minimized. The employment scales reflect that many people want to work.

Goals for 2009

The following goals were set for 2009:

1. Each division of the agency will adhere to their quality assurance procedures. This involves matching the billing with the documentation and reviewing documentation for quality. *The Behavioral Health division adopted and implemented QA procedures.*

2. We will develop at least two providers for crisis stabilization beds for children. Several children's' foster home providers were trained in Crisis Intervention. *One provider delivered these services for adolescents.*

3. The Lueder Haus Consumer Council will be formed. This Council will be asked to review the rules and procedures of the Lueder Haus and make suggestions to improve the ongoing programming. *Several meetings were held with consumers to get their input.*

4. We will review and streamline all of our EMH forms. *The Initial Crisis Assessment, Response plan, and financial intake forms were streamlined into one Crisis Assessment form.*

5. We will review and streamline all of our EMH procedures and systems across the agency, including the billing and secretarial systems and staff. *We continue to works towards this goal.*

6. We will improve our data tracking by insisting on consistency in our coding and defining what diversion from emergency detention means for all staff. *We need to continue to work towards this goal.*

7. We will participate in the regional Emergency Mental Health grant for training resources and money. *We are participating in the southeast region Crisis grant. We have used approximately $4500 from the grant to purchase the Incredible Years curriculum which will use to build the skills of our foster parents.*

8. The Lueder Haus staff will receive additional training and all staff will be trained in trauma informed care. *The Lueder Haus staff watched the web casts from the Trauma Informed care conferences.*

Goals for 2010

1. Improve our data recording efforts by training and reviewing with all EMH staff necessary definitions and procedures.

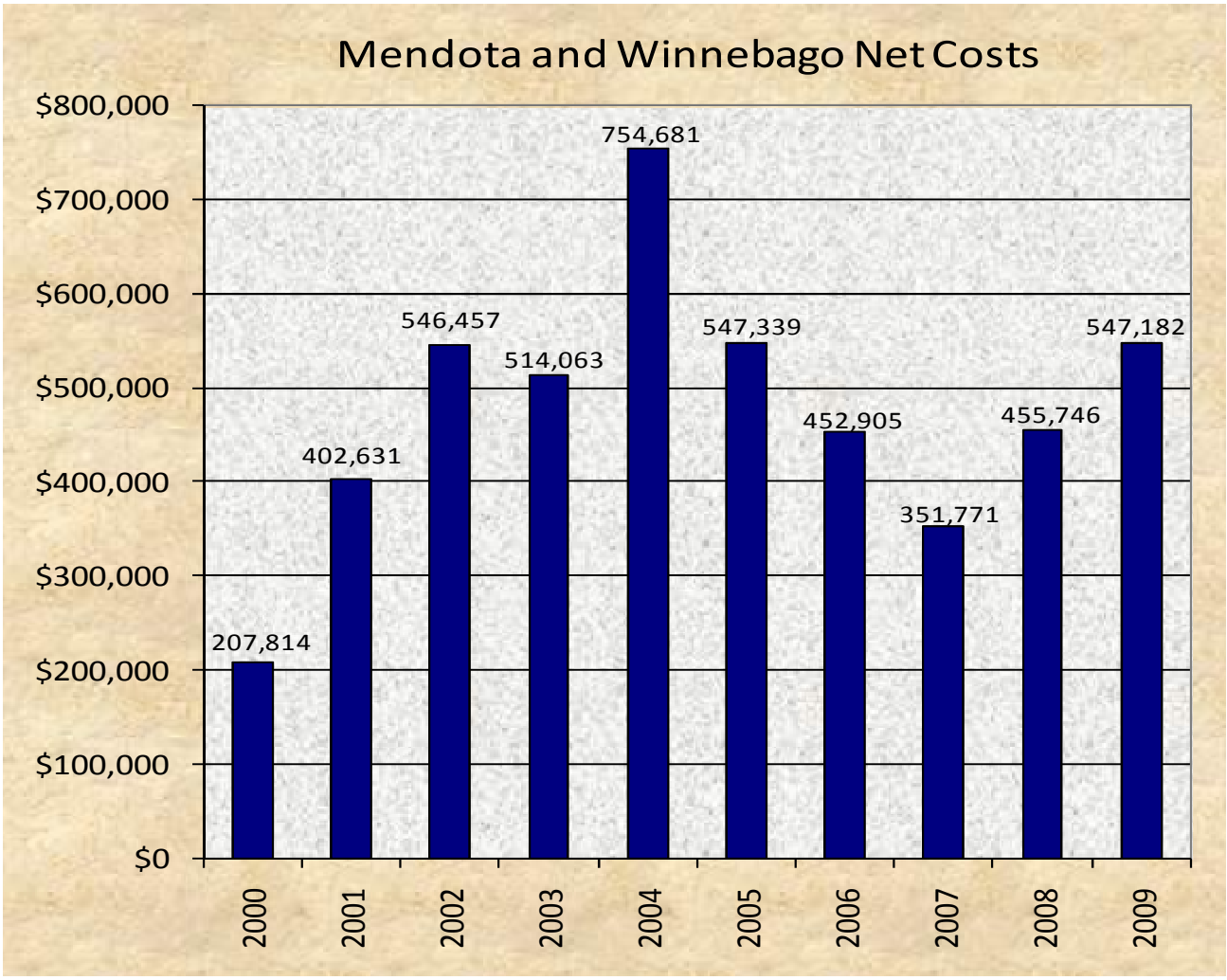
2. Complete all requirements for the southeast region crisis grant.

3. Review and enhance quality assurance methodology.

4. Provide training for all EMH staff.

5. Hold one annual meeting with consumers of EMH services to gather feedback, review concerns, and plan for the future.

The following graph summarizes psychiatric inpatient costs at Mendota Mental Health Institution for the past 10 years, from 2000 to the present. As the graph indicates, this is an important and volatile area. Costs are difficult to predict due to the nature and circumstances of persons who are mentally ill and require treatment and protection. Consequently, significant efforts are made to provide community based treatment as an alternative to hospitalizations. These include our Emergency Mental Health program and our Community Support Program as described above. Overall, 2009 was a successful year in terms of improved treatment programming and reducing hospital costs. Our 2009 hospital costs were $100,000 less than budgeted for this area for the year. This was accomplished by the continuing use and development of our Community Support Program, Comprehensive Community Services Program, and Emergency Mental Health Program. Detailed results for these programs follow.



Adult Alternate Care

~Our goal is to assist individuals to live with support and dignity in the community~

Human Service's Adult Alternate Care program provides care for individuals who present life struggles such as mental illness, alcohol or drug dependency, developmental and physical disabilities or infirmities of aging. Our goal is to assist individuals to live with support and dignity in the community.

The following chart provides summary numbers for adult alternate care placements.

ADULT PLACEMENTS					
PROGRAM - (In County)	**2005**	**2006**	**2007**	**2008**	**2009**
Lueder Haus	163	178	217	172	214
READMISSIONS	79	94	123	88	103
Developmentally Disabled	230	228	303	290	48
Elderly	35	31	55	55	1
Physically Disabled	19	15	24	23	0
AODA	2	0	0	0	0
Mentally Ill	46	36	33	31	33
PROGRAM - (Out of County)					
Developmentally Disabled (Group Homes)	15	11	13	15	6
Elderly (Group Homes)	29	32	41	27	0
Physically Disabled	10	5	6	6	0
AODA (Group Homes)	14	6	7	18	11
Mentally Ill (Group Homes)	9	5	6	9	8
HOSPITALS					
AODA Detoxification	81	84	46	65	68
Mental Health Institutions	115	80	70	74	75
Private Psychiatric	8	3	5	4	1

The above data on placements reflects the changes the department experienced with the advent of Family Care and Partnership. The placements for people who are elderly, developmentally disabled and physically disabled are now provided by our Care Management Organization, Care Wisconsin.

AGING & DISABILITY RESOURCE CENTER

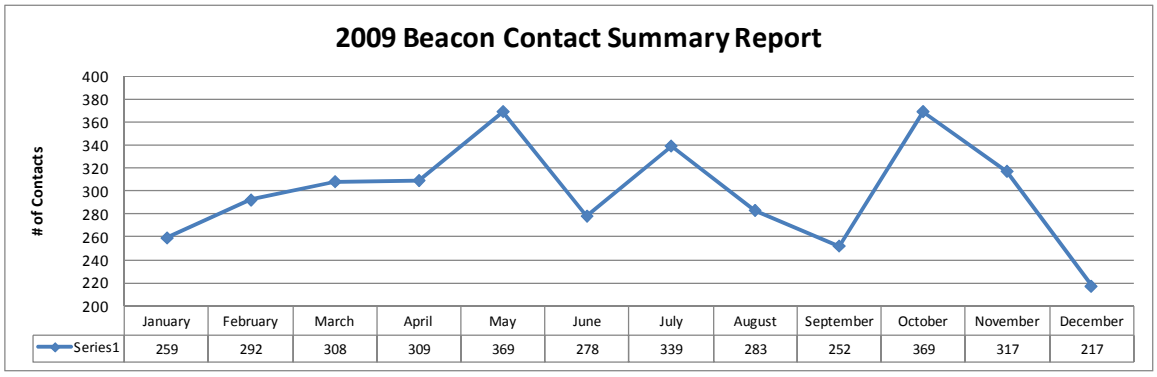
~ADRCs are service centers that provide a place for the public to get accurate, unbiased information on all aspects of life related to aging or living with a disability.~

ADRCs are service centers that provide a place for the public to get accurate, unbiased information on all aspects of life related to aging or living with a disability. Individuals, family members, friends or professionals working with issues related to aging, physical disabilities, developmental disabilities, mental health issues, or substance use disorders, can receive information specifically tailored to each person's situation.

ADRCs are also places where people can access Wisconsin's publicly funded long term care programs, including Family Care and Partnership (managed care) and the Self-Directed Supports Waiver Program called IRIS, *Include, Respect – I Self Direct.*

In 2009, the ADRC had 3,591 contacts. Contacts include phone calls, home visits, letters and emails. 57% of known contacts were on behalf people 60+; 28% were made on behalf of people between the ages of 18-59 and 10% were regarding children under the age of 18. The primary reason that people contacted the ADRC was for information related to health/in-home services.

The ADRC continues to receive a high volume of calls from people who are interested in publicly funded long term care, and ADRC staff completed 376 long term care functional screens in 2009. Screens are offered to anyone who is interested in applying for publicly funded long term care and the results establish functional eligibility for managed care or IRIS. Many of the screens completed in 2009 were for people living in skilled nursing facilities (SNF's), intermediate care facilities for the mentally retarded (ICF-MR's) and facilities for developmentally disabled (FDD's). People living in any of these settings are exempt from the waiting list and are eligible to enroll in publicly funded long term care when they request it and all eligibility requirements are met.



Following is a summary of the ADRC's community relocation enrollment activities:

ICF MR Relocations: Options counseling was provided to 14 individuals and their legal representatives in conjunction with a closing or downsizing agreement between St. Coletta's and the Department of Health Services. Twelve individuals enrolled into managed long term care programs.

Community Relocations for Nursing Homes: Individuals residing in a skilled nursing home, who are also on Medicaid, are exempt from waiting list requirements. The ADRC provided 64 individuals living in nursing

homes with options counseling, and 40 of them opted to enroll into a publicly funded long term care program so that they were able to relocate from the nursing home.

The 2009-2010 state budget extended the county's waiting list for another year and reduced the number of people who can be enrolled from the waiting list from seven per month to four. Entitlement for publicly funded long term care is expected to begin on 9/1/2011 unless the 2011-2012 state budget changes this. All people who were on the waiting list prior to the county's transition to Family Care have now been served; however, the list continues to grow. At the end of December 2009, the waiting numbers were nearly equal to what they were at the onset of managed care (168).

As people go off the waiting list via attrition, those "slots" can be filled with waiting list people. This resulted in 37 additional enrollments of people who were on the wait list. When combined with community relocations, the ADRC enrolled 159 total people into Family Care, Partnership or IRIS in 2009!

The final group of individuals who are exempt from the waiting list are children who are on the Children's Long Term Support Waiver Program (CLTS-W) and who are turning 18 before entitlement. At age 18, this group of individuals is no longer eligible for children's long term support services because they have the option of enrolling in managed care or IRIS. A small subset of this group is eligible for the CLTS-W due to a diagnosis of Severe Emotional Disturbance and most often these children will not qualify for the adult programs. In these cases, those individuals can remain on the CLTS-W until age 22.

Goals/Strategies for 2010

ADRC's are expected to provide all contractually required services in a competent and professional manner. In order to ensure that quality services are provided, the ADRC will implement the following quality indicators in 2010:

- Satisfaction surveys shall be distributed monthly.
- Individuals requiring follow-up calls shall be identified and contacted via telephone on a monthly basis.
- Requests for long term care functional screens shall be responded to within 14 days of the initial call so that individuals experience a timely, streamlined process for eligibility determination.
- The resource database will be updated every six months or as needed in accordance with the taxonomy established by the Department of Health Services.
- All staff will become Certified Information & Referral Specialists (CIRS) via the national Alliance of Information & Referral Systems in order to understand their role in relation toward the movement for a national service delivery system.
- Ongoing training will be offered to Aging & Disability Specialists to help them remain up-to-date with program/resource changes so that information is relevant to the caller.

Jefferson County Senior Dining Program

Fellowship, Food Fun

In 2009, Jefferson County's Senior Dining Program underwent some significant changes: 1) The Rome site was closed on 1/1/09, and 2) The Nutrition Outreach Worker's position was expanded and now includes site manager responsibilities at the Jefferson site.

The closing of the Rome site was due to low participation in the congregate program; however, home delivered meals were still made available in that area due to the dedicated delivery volunteers and willingness

of the caterer to prepackage meals. This change resulted in approximately $11,000 cost savings to the county and uninterrupted service to some of our most rural senior citizens.

The second change occurred due to budget constraints. The Nutrition Outreach Worker position became a hybrid when it was merged with a Senior Dining Site Manager position. "Essential" duties of both job descriptions remain unchanged, but nonessential functions were eliminated. This resulted in the discontinuance of the evidence-based *Chronic Disease Self-Management Program* that was developed by Stanford University's Patient Education and Research Center. The change results in another $11,000 cost savings to the county.

The Senior Dining Program saw no appreciable difference in meals served between 2008 & 2009. The program served 35,534 hot, noon meals to the elderly and people with disabilities; the congregate sites served 15,696 meals, and 19,838 home deliveries were made. In addition to meals, the Senior Dining Program provides participants with 141 units* of nutrition counseling and 89 units of medication management.

*Units = 1:1 interactions with the Nutrition Outreach Worker who is the program's Nutritionist.

Goals/Strategies for 2010

The Senior Dining Program has seen a steady decrease in the number of meals served over the past seven years. Some of this decrease is attributed to several policies and procedures that have been put in place to decrease waste, increase accountability and control costs. Little is known, however, about the reasons for this decline from the consumer perspective. Many sites continue to have participation problems, despite offering activities in a convenient, welcoming environment.

The Aging & Disability Resource Center Advisory Committee selected the Palmyra Senior Dining Site to undergo an extensive outreach campaign in 2010. The site is one of our most rural; the site itself is located in a senior apartment complex, but there is no senior center. To encourage participation, the site manager regularly organizes activities and events that draw on the talents of civic organizations and children at the various schools.

According to the last census, Palmyra is home to 475 people aged 60+; all of these people are potential program participants, yet only 43 of them attended the site in 2009, and only a handful of them are "regulars." Approximately 12 meals are served each day. Due to concerns about the "health" of this site, Nutrition Program staff will undertake the following activities in order to study the issues around underutilization:

- A focus group will be held with seniors residing in the Palmyra Park Apartments to gather their feedback as to why the majority of them don't participate in the program.
- All Palmyra seniors will have the opportunity to participate in a Senior Dining Program survey.
- The program will be heavily marketed throughout Palmyra via posters, brochures, bulletins, and news articles.
- An "Ask Me about Senior Dining" button or t-shirt campaign that relies on local volunteers will be explored.

Transportation Services

Jefferson County provides transportation services to the elderly and persons with disabilities via volunteer drivers and one paid van driver. Services are funded via the s85.21 Specialized Transportation Program, Medicaid, county tax levy, voluntary contributions and passenger co-payments. Persons seeking access to medical care are given priority services, as well as those needing help in meeting their nutritional needs.

There are various transportation providers in Jefferson County, and they each work independently of each other. The ADRC has a "locally" developed Coordination Plan which was developed in collaboration with the other transportation providers and the first goal listed below comes directly from that plan.

Jefferson County provides the following services:

1. Elderly Services Van: Provides transportation on a fixed route basis to elderly and disabled individuals for grocery and other shopping trips. In 2009, 3,285 one-way trips were provided. Passengers are asked for a $1.00 donation per trip.

2. Taxi Program Subsidy: Provides a user-side subsidy for taxi services provided to elderly who use the taxi in order to attend a Senior Dining Program in Fort Atkinson, Jefferson and Lake Mills. In 2009, 781 one-way trips were subsidized at .75 per trip.

3. Driver-Escort Program (volunteer drivers): Provides door-to-door transportation to elderly and disabled individuals for medical appointments when they have no other transportation options. In 2009, volunteer drivers provided 4,884 one-way rides. Passengers are asked for a $1.00 co-payment per in-county trip and a $5.00 co-payment per out-of-county trip.

Goals/Strategies for 2010

- Improve coordination between providers and passengers in order to increase transportation options and accessibility to special populations (elderly, disabled, low-income).
- Attend or facilitate quarterly coordination meetings with providers, consumers and interested others.
- Explore grant opportunities that would provide funding for a Mobility Manager.
- Update the Coordination Plan.

Benefit Specialists

The Elderly Benefit Specialist (EBS) program closed 1,424 cases between 10/1/2008 and 9/30/2009. It served 726 clients and provided a monetary impact of $1,207,461 in recouped federal/state/other dollars for Jefferson County's elderly residents! The program provides advocacy and assistance to Jefferson County residents age 60 yrs or old who have questions or are having problems with public benefit programs.

In 2009, the EBS program exceeded their goal to increase participation in FoodShare (FS) cases by 20% with FS cases actually up by 25%; thus, more households of elderly seniors now have access to adequate nutrition. Sadly, the program also noted a dramatic upsurge (by 133%) of the number of cases involving debt collections for credit card and speedy payday loans.

In 2010 the focus of the EBS program will be on increasing the numbers of Low Income Subsidy applicants for the Medicare Part D program, including higher participation in Medicare Savings programs (QMBs/SLMBs) by 20%. This will be accomplished by comprehensive benefit check screenings during the Homestead Tax Credit

appointments, accurate information provided at Medicare workshops and by continued visibility in the Hispanic community. The EBS program will submit quarterly press releases regarding benefits programs in the La Conexiones (a publication for Spanish speaking residents) and participate in the annual Latino Resources Expo which will be held at the Jefferson County Fairgrounds.

As in the previous year, Medicare Part D and all its complexities remains the most sought after topic for counseling. The EBS program closed 212 Part D plan comparison cases (39% increase) resolved 46 coverage disputes (50% increase) and assisted with 76 Low Income Subsidy applications (24%). The ABCS of Medicare workshops have gained popularity and will continue in 2010. There is tremendous weight given to the collaboration between EBS and the Wisconsin SHIP program and the Jefferson County EBS program continues to try to provide excellent service and also meet the demands of performance measures sought by the State and CMS.

Goals/Strategies for 2010

- Utilize modern technology to provide interactive training sessions to consumers:
    - The Medicare workshop will now include an online demonstration of how to utilize the CMS link available at www.medicare.gov, and
    - The next ABCs of Medicare workshop will be broadcast on a local community cable access channel.
- Transfer responsibilities under the WI Homestead Tax Credit Program to AARP or other tax assistance programs.
- Investigate the use of volunteers to perform State Health Insurance Assistance Program (SHIP) activities.
- Complete 100% time reports daily to capture additional state and federal funds to fully fund the program.

The Disability Benefit Specialist (DBS) works with people with disabilities aged 18-59 and spends much of her time working with people who are interested in applying for Medicaid, Social Security Disability or appealing a benefit denial. From 1/1/09-12/31/2009, the DBS worked on 317 cases. The individuals served identified themselves as having a physical disability (49%); mental health issue (29%) or developmental disability (10%). The majority of people served were between the 40-59 age groups. The monetary impact in terms of benefits for consumers totaled $797,382!

Goals/Strategies for 2010

- To increase accessibility, establish a satellite location in the City of Watertown.
- To increase consumers awareness about the Food Share Program.

Family Caregiver Support Programs

The department currently coordinates caregiver services and benefits under the following two programs: 1) Family Caregiver Support Program; and 2) Alzheimer's Family Caregiver Support Program. These programs are intended to provide caregivers with information about available services; assistance in gaining access to services; individual counseling, support groups and training; respite care to give them a break from providing care and supplemental services to help provide care.

Goals/Strategies for 2010

- Caregiver services will be coordinated with other organizations that support them. The ADRC will initiate this process by hosting an informational/organizational meeting for providers and consumers.

- In order to better address the needs of caregivers, a Caregiver Coalition will be developed and the coalition will at a minimum, meet twice per year.

- In order to increase awareness around the unmet needs of caregivers, an annual in-service will be provided to Aging & Disability Specialists to train them to respond to the needs of caregivers who are calling the ADRC for information and assistance on behalf of the care recipient.

Adult Protective Services

Abuse & Neglect of Vulnerable Adults & the Elderly

Jefferson County is experiencing an unprecedented rate of unemployment and many elders are opening their homes to family members. For some, this trend has resulted in some unexpected consequences. Reports of Abuse & Neglect of Vulnerable Adults (18+) is under the umbrella of the Adult Protective Services Unit (APS) and in 2009 there was an increase in the number of financial abuse referrals. APS has also had several requests for assistance from elders to help them get their family members out of their homes due to financial concerns.

Goals/Strategies for 2010

- To increase awareness of elder financial abuse, the Elder Abuse I-Team's Financial Abuse Subcommittee will develop a financial abuse prevention program.

- In order to heighten awareness, the ADRC will distribute a quarterly newsletter or articles about abuse/neglect to organizations that work with the elderly.

Guardianship/Protective Placements & Annual Placement Reviews

The APS unit is responsible for ensuring that the health and safety needs of individuals with cognitive disabilities are met when they are in situations where substantial risk is evident. In Wisconsin, individuals with guardians are required to have a protective placement order when they are residing in a state center, skilled nursing facility or facility for the developmentally disabled. Protective placement orders are reviewed annually to ensure that the individual is living in the "least restrictive environment."

Prior to the closing of the Alverno ICF-MR, the Department of Health Services completed the annual WATTS reviews on individuals in both Alverno and Bethesda. Now that there is only one ICF-MR in Jefferson County, the WATTS reviews on Bethesda residents has reverted back to the county.

The Human Services Department, Corporation Counsel, Register-in-Probate, Clerk of Courts and Circuit Courts are currently overwhelmed with all of the duties associated with guardianship/protective placement referrals, evaluations, court hearings, WATTS reviews, other administrative functions and all related costs.

Goals/Strategies for 2010

- The department's guardianship policy will be reviewed and updated to reflect the counties overall policies, procedures and costs.
- Non-emergency County provided guardianship services, or associated services will be eliminated to the fullest extent possible.
- When individuals are relocated from institutional settings, the APS unit will recommend dropping the court order for placement when appropriate.
- The fee collection process will be updated.

ADMINISTRATIVE SERVICES DIVISION

~The Administrative Services Division provides the support, maintenance, fiscal duties and oversight for the department to complete the necessary work~

The Administrative Services Division includes three sections overseen by a division manager. Our Maintenance team consists of a supervisor, three full time employees, and one part time employee. They ensure that the buildings and grounds are in working order.

Our Support Staff team consists of a Office Manager/supervisor, 5 full time employees and two part time employees. They ensure that appointments are scheduled, phones are answered, records are maintained and filed and all other support duties are completed.

Lastly, the Fiscal team has ten full time employees and one part time employee. They ensure that all accounting, data tasks, and all financial reports are accomplished for the department.

One of the largest areas this division has primary responsibility for is the creation and monitoring of the department/s budget. This includes the budgeting for the wages of full time and part time employees, as well as their benefits and associated costs. As the organizational charts show,(pg 6 for 2009 and page 71 for 2010), the Department will have 12 less full time employees and two less part time employees. This is primarily the result of Family Care, as the Developmental Disabilities/Long Term Care with the respective positions, 1 supervisor and 13 case managers were eliminated. Additional positions were unfunded when employees departed the agency.

Division Goals for 2010

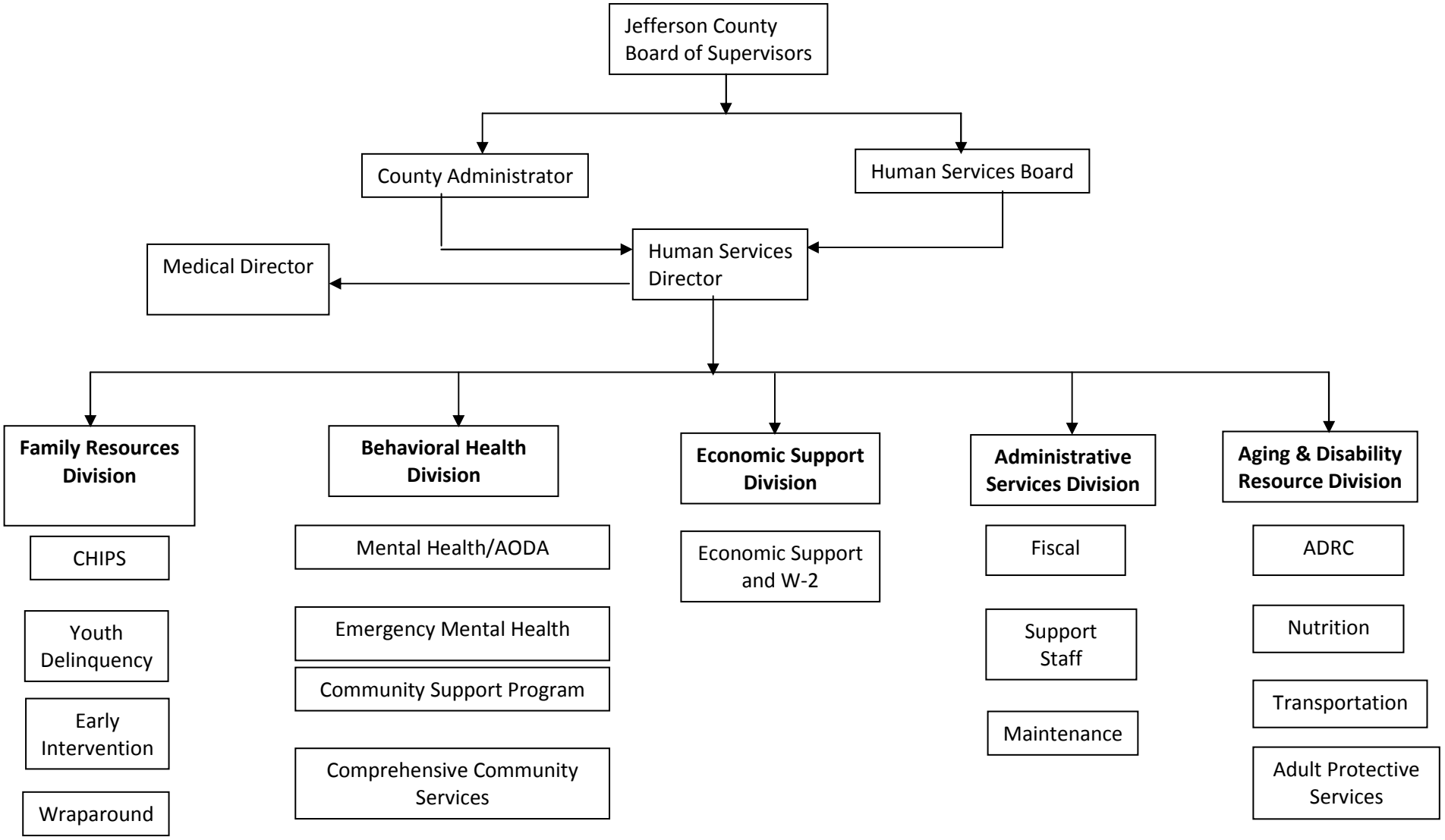
Goal number one: The 2011 budget will be re-organized in a performance driven manner so that program expenditures match program revenues within each division. This will ensure managers have the information they need to monitor their programs and that data is summarized at a division level.

Goal number two: Employees will have detailed job manuals written. This will allow staff to be cross-trained, be more efficient, and be able to complete job functions when an emergency or vacancy arises.

Goal number three: Automate electronic billing to medical assistance versus paper claims.

Goal number four: Implement a fiscal system for Home and Community-Based Services CRS/1915i to capture data to bill medical assistance for the program back to January 1, 2010.

2010 Organizational Chart



TOTAL POSITIONS FTE – 145.5, 14 PT

FINANCIAL REPORTS

The Financial Reports that follows summarize Department resources and expenditures by source and type, by target group, and by service type. Data are presented in numeric and pie chart formats. Total resources for 2009, including County tax levy, were $

2009 Resources & Expenditures

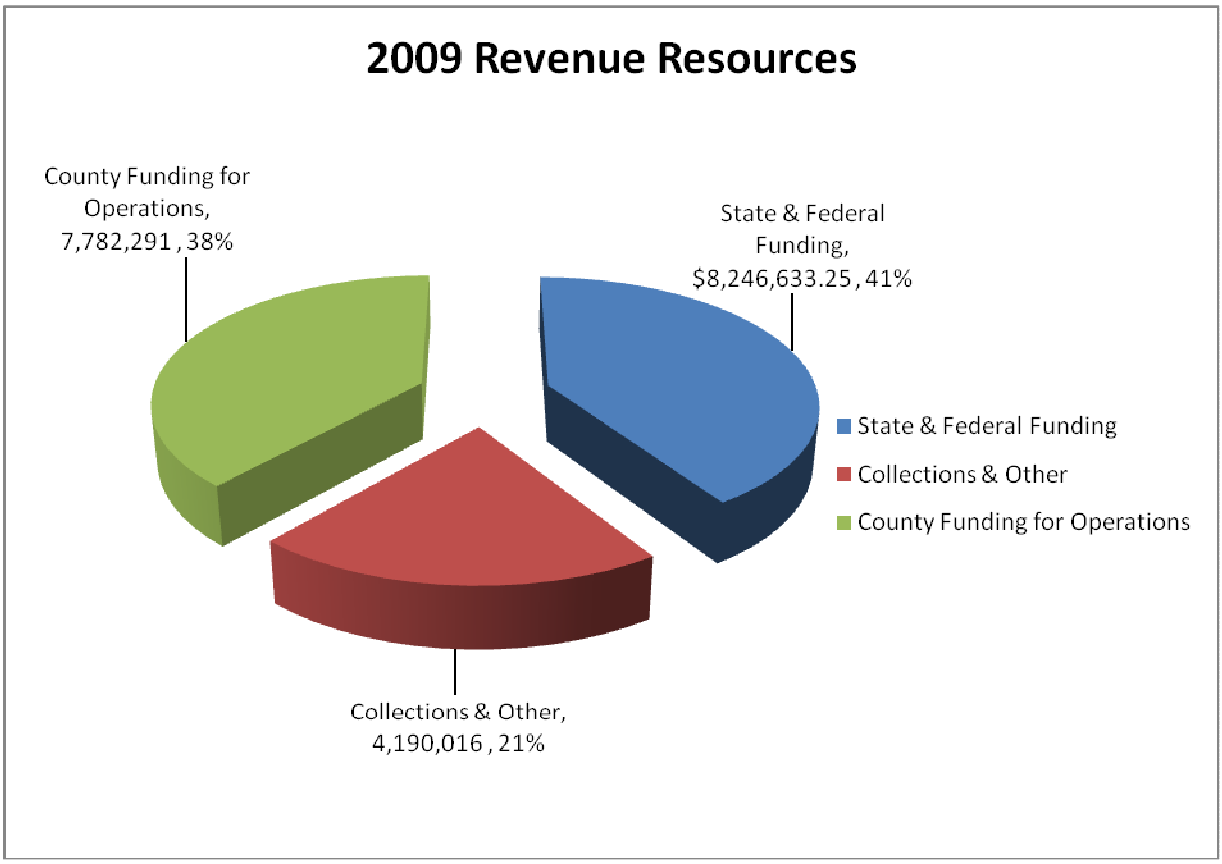
(unaudited)

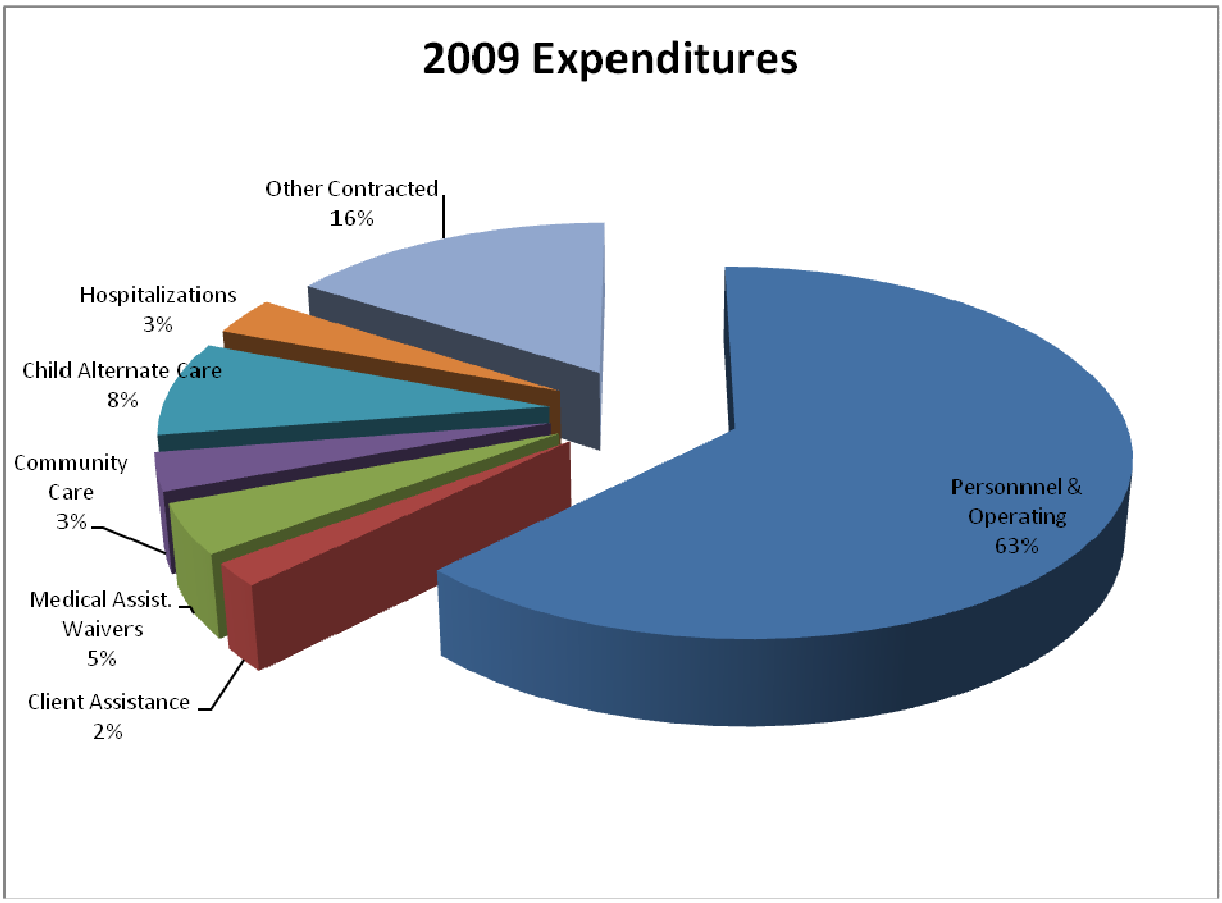
RESOURCES:	ACTUAL	Budget	Variance
State & Federal Funding	$ 8,246,633.25	$ 7,856,649.00	$ 389,984.25
Collections & Other	4,190,016	4,436,422	(246,406)
County Funding for Operations	7,782,291	7,768,551	13,740
Total Resources	$ 20,218,940	$ 20,061,622	$ 157,318

EXPENDITURES:	ACTUAL	Budget	Variance
Personnnel & Operating	$ 12,843,102.44	$ 13,245,223.00	$ 402,120.56
Client Assistance	424,067	304,700	(119,367)
Medical Assist. Waivers	911,945	638,000	(273,945)
Community Care	691,454	572,530	(118,924)
Child Alternate Care	1,720,815	1,500,000	(220,815)
Hospitalizations	691,799	601,000	(90,799)
Other Contracted	3,231,102	3,200,169	(30,933)
Total Expenditures	$ 20,514,286	$ 20,061,622	$ (452,664)

SUMMARY	VARIANCE	PERCENT
Resources	157,318	0.78%
Expenditures	(452,664)	-2.26%
Net Deficit	(295,346)	-1.47%

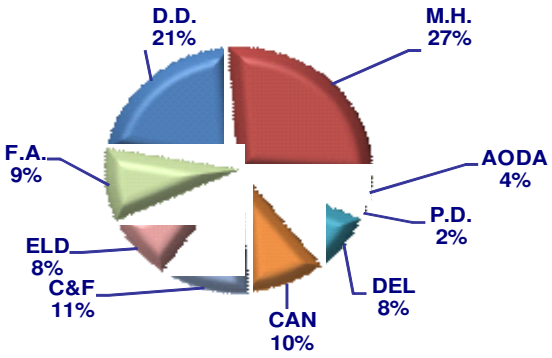
2009 operations resulted in a net deficit of -$295,346 (-1.47% of total budget, which was funded by the County General Fund).


2009 Revenue Resources
County Funding for Operations, 7,782,291 , 38%
State & Federal Funding, $8,246,633.25 , 41%
Collections & Other, 4,190,016 , 21%
State & Federal Funding
Collections & Other
County Funding for Operations

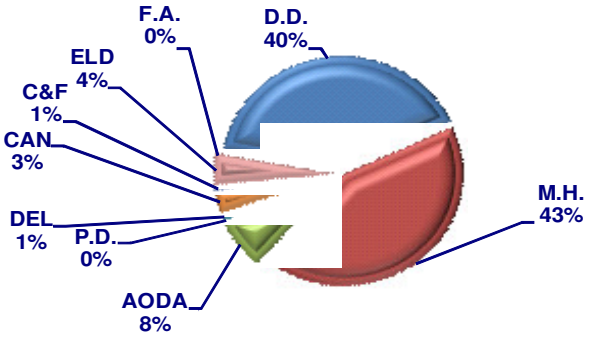

2009 Expenditures
Other Contracted 16%
Hospitalizations 3%
Child Alternate Care 8%
Community Care 3%
Medical Assist. Waivers 5%
Client Assistance 2%
Personnnel & Operating 63%

Costs by Target Group

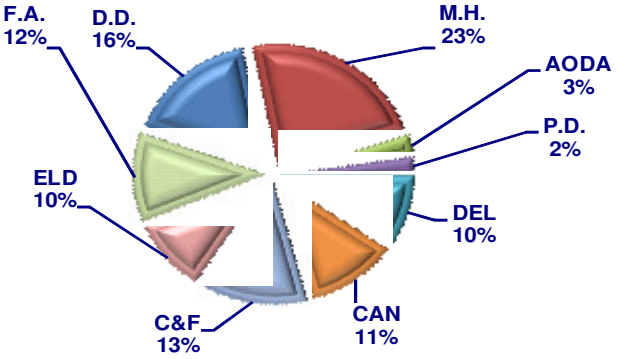
Total Expenditures		
Develop. Disabilities	***D.D.***	4,325,550
Mental Health	***M.H.***	5,563,108
Alcohol & Drug	***AODA***	793,133
Physical Disabilities	***P.D.***	346,942
Delinquency	***DEL***	1,610,640
Child Abuse/Neglect	***CAN***	1,975,303
Children & Families	***C&F***	2,203,679
Elderly	***ELD***	1,744,898
Financial Assistance	***F.A.***	1,951,032
TOTAL		20,514,285



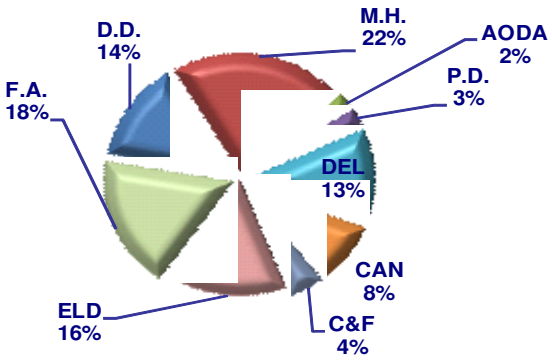
Collections & Donations		
Develop. Disabilities	***D.D.***	1,647,682
Mental Health	***M.H.***	1,770,305
Alcohol & Drug	***AODA***	304,168
Physical Disabilities	***P.D.***	0
Delinquency	***DEL***	43,847
Child Abuse/Neglect	***CAN***	125,793
Children & Families	***C&F***	28,836
Elderly	***ELD***	172,887
Financial Assistance	***F.A.***	0
TOTAL		4,093,518



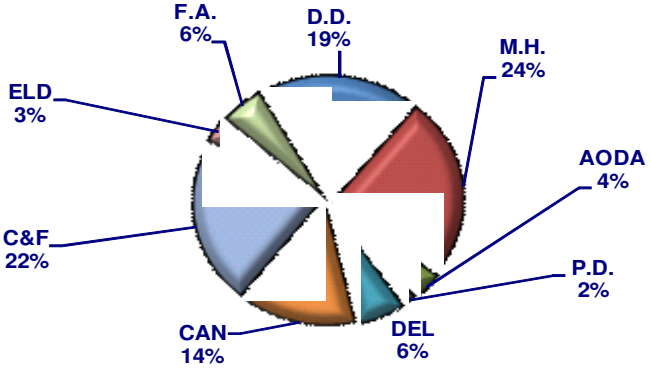
Net Costs		
Develop. Disabilities	***D.D.***	2,677,868
Mental Health	***M.H.***	3,792,803
Alcohol & Drug	***AODA***	488,965
Physical Disabilities	***P.D.***	346,942
Delinquency	***DEL***	1,566,793
Child Abuse/Neglect	***CAN***	1,849,510
Children & Families	***C&F***	2,174,843
Elderly	***ELD***	1,572,011
Financial Assistance	***F.A.***	1,951,032
TOTAL		16,420,767

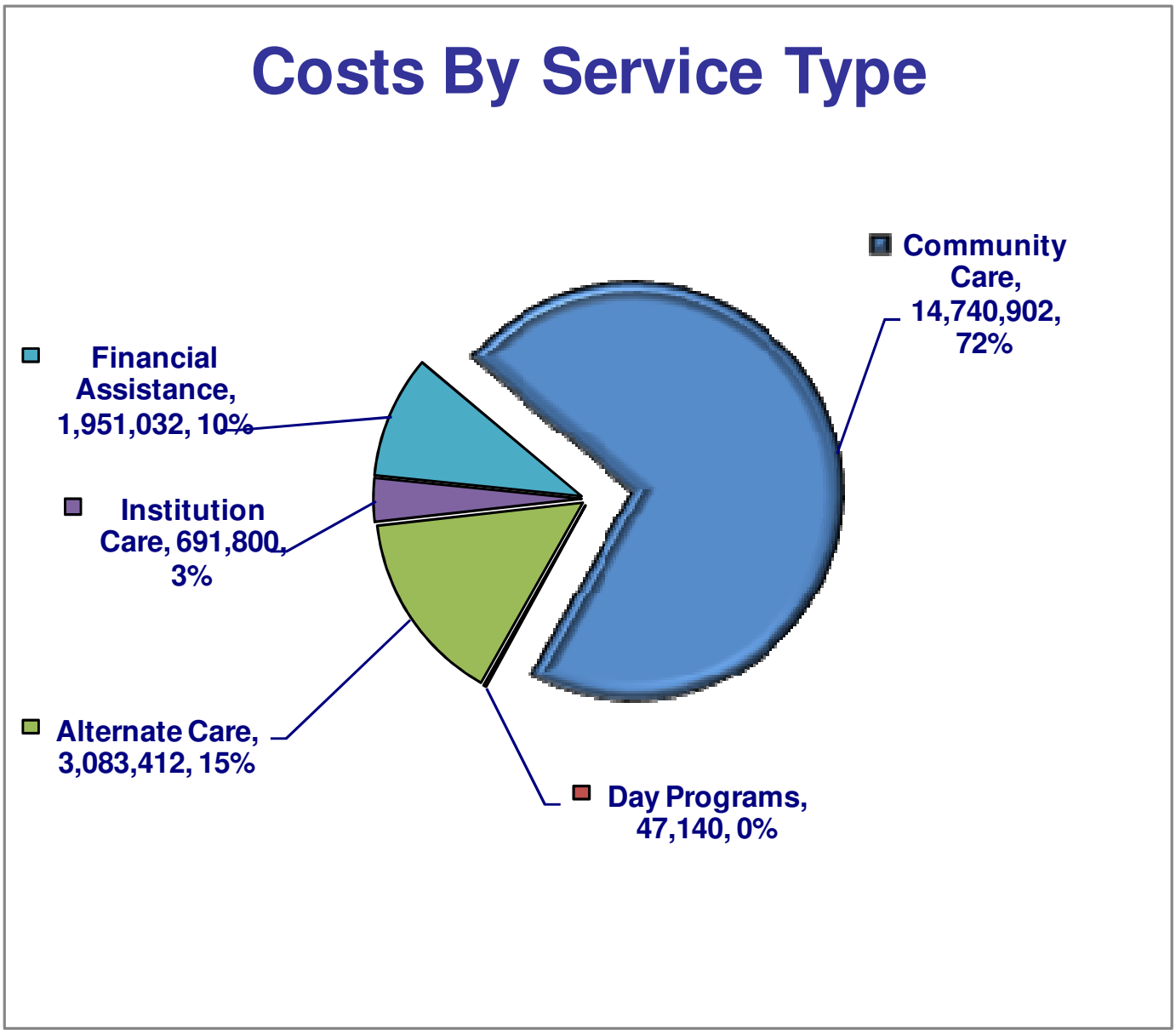


State & Federal Funding		
Develop. Disabilities	***D.D.***	1,129,794
Mental Health	***M.H.***	1,821,727
Alcohol & Drug	***AODA***	179,753
Physical Disabilities	***P.D.***	220,642
Delinquency	***DEL***	1,086,692
Child Abuse/Neglect	***CAN***	694,628
Children & Families	***C&F***	376,853
Elderly	***ELD***	1,297,081
Financial Assistance	***F.A.***	1,510,808
TOTAL		8,317,978



Net County Cost		
Develop. Disabilities	***D.D.***	1,548,074
Mental Health	***M.H.***	1,971,076
Alcohol & Drug	***AODA***	309,212
Physical Disabilities	***P.D.***	126,300
Delinquency	***DEL***	480,101
Child Abuse/Neglect	***CAN***	1,154,882
Children & Families	***C&F***	1,797,990
Elderly	***ELD***	274,930
Financial Assistance	***F.A.***	440,224
TOTAL		8,102,789




Costs By Service Type
Community Care, 14,740,902, 72%
Financial Assistance, 1,951,032, 10%
Institution Care, 691,800, 3%
Alternate Care, 3,083,412, 15%
Day Programs, 47,140, 0%

Heath Insurance Portability And Accountability Act

~ The proper use and disclosure of protected healthcare information, while maintaining confidentiality, integrity and availability in the hybrid county workplace, is the goal of county-wide HIPAA implementation.~

HIPAA is the complex set of **federal standards** with a direct impact on the treatment, payment, and healthcare operations (TPO) of the Jefferson County Health, Human Services, Human Resources (employee health care information) and Management Information System (MIS) Departments; Countryside Home and the Jefferson County Jail. Human Services employee Charlotte Silvers was designated by County Board Resolution No. 2004-108 to the combined role of HIPAA Privacy and Security Officer in 2005 with the assistance of Deputies in each of the covered entity departments as designated in County Board Resolution No. 2003-05. See also the previously distributed 2005, 2006, 2007and 2008 Human Services Annual Reports for past HIPAA reviews.

In addition to many of the HIPAA activities reported in previous annual reports continuing into 2009, a major federal legislative initiative to enhance HIPAA regulation resulted in passage of the American Recovery and Reinvestment Act of 2009. Within ARRA is a 40+ page section known as the Health Information Technology for Economic and Clinical Health (HITECH Act) which allocates funds for the nationwide health information exchange and health information use. ARRA has already made major changes to the HIPAA privacy and security provisions, and will continue to do so per a set timetable that will:

1. Impact all HIPAA covered entities as well as entities holding healthcare information outside of the covered entities as business associate and subcontractors of business associates. BA's and subcontractors now come directly under more of the HIPAA provisions. Breaches and the reporting of breaches related to personal health information privacy are also dealt with in the new language,
2. Set new definitions for electronic health records, breaches, and personal health records. Definitions for DeIdentification and Minimum Necessary are being reviewed,
3. Publish guidance on many aspects of ARRA, by the federal Department of Health and Human Services,
4. Changes in accounting of disclosures to include Treatment, Payment, and Healthcare Operations (TPO) previously excluded. Users of Electronic Health Records (EHR) must comply based on the year the covered entity's EHR was installed, and,
5. Clarify marketing and sale of protected health information.

ARRA also calls for:

1. The appointment of a new privacy official in the now-permanent Office of the National Coordinator for HIT (ONCHIT).
2. The establishment of regional privacy education efforts,
3. Enforcement tightened with increased and clarified privacy penalties,
4. Privacy audits, and,
5. Several other categories of changes and clarifications.

The changeover to the latest HIPAA Transaction and Code Set Standard 5010 for billing of healthcare services and ICD-10-CM for diagnosis coding continues. It has been said that the effort of Congress and the President to reform healthcare will not delay the already announced dates that require the changes in transaction and code set in 2012/2013, respectively. Efforts continue to be directed towards implementation of EHR in Wisconsin with a governor-announced summer of 2010 establishment of basic structure, and the Nationwide Health Information Network (NHIN) without delaying the already announced implementation in the year 2014. In order to learn about the above ARRA changes and contribute to the effort to maintain current compliance, I served as a member of two HIPAA Collaborative of Wisconsin workgroups: Business Associate Addendum and Breach Notification. Both workgroup deliverables are posted on the HIPAA COW website at www.HIPAACOW.org

HUMAN SERVICES MANAGERS & SUPERVISORS

Director, *Kathi Cauley*

Medical Director, *Mel Haggart, M.D.*

Administrative Services Division Manager, *Joan Daniel*

Maintenance, *Terry Gard*

Office Manager & Support Staff, *Donna Hollinger*

Aging and Disability Resource Division Manager, *Sue Torum*

Aging & Disability Resource Center, *Sharon Olson*

Behavioral Health Division Manager, *Kathi Cauley*

Community Support Program, *Marj Thorman*

Comprehensive Community Services, *Kim Propp*

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